Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust

Royal Shrewsbury Hospital

Quality Report

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743 261000
Website: www.sath.nhs.uk

Date of inspection visit: 14-16 and 27 October 2014
Date of publication: 20/01/2015

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Inadequate
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales; 90% of the area covered by the trust is rural. There are two main locations, Royal Shrewsbury Hospital in Shrewsbury and Princess Royal Hospital in Telford. The trust also provides a number of services at Ludlow, Bridgnorth and Oswestry Community Hospitals.

Royal Shrewsbury Hospital was formed in 1979 after a number of hospitals in the town were closed or merged. The hospital provides a wide range of acute hospital services, including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. The hospital is also the main centre for acute and emergency surgery, and has a trauma unit that is part of the region-wide network. It is the main centre for oncology and haematology.

We carried out this comprehensive inspection because the trust had been flagged as a potential risk on CQC's intelligent monitoring system. The inspection took place between 14 and 16 October 2014, with an unannounced inspection on 27 October.

Overall, this trust requires improvement. We found that services for children and young people, maternity and gynaecology, and outpatients were good. Urgent and emergency care, critical care, surgery, medicine and end of life care services required some improvements to ensure a good service was provided to patients. Caring for patients was good, but requires improvement in providing safe care, effective care, being responsive to patients' needs and being well-led in some areas.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The hospital was visibly clean and well maintained. Infection control rates in the hospital were lower when compared with those of other hospitals.
- Patients' experiences of care was good and the NHS Friends and Family test was in line with the national average for most inpatient wards, but was better than the national average for A&E.
- The trust had recently opened the Shropshire Women's and Children's Centre at the Princess Royal site, and all consultant-led maternity services and inpatient paediatrics had moved across from the Royal Shrewsbury site. We found that this had had a positive impact on these services.
- The trust has consistently not met the national target for treating 95% of patients attending A&E within four hours. At Royal Shrewsbury Hospital some improvements were also needed in the safe, effective and well led domains in A&E.
- There was some good care delivered in the medical wards, but high staff vacancies and heavy reliance on bank and agency staff was putting considerable pressure on the existing staff.
- We were concerned about ward 31 at Royal Shrewsbury Hospital, which was being used for day surgery patients while the purpose-built day surgery unit was being used for inpatients. The heating had not been switched on and there was no emergency call bell and staffing on this ward was a concern. Although the trust addressed these issues immediately when we brought them to their attention, this arrangement does not provide day-case patients with an effective service.
- The hospital was not meeting the Core Standards for Intensive Care Units. We were concerned about nurse staffing levels and asked the trust to look at the situation immediately. During our unannounced inspection we were pleased to see the trust had responded.
- The trust had recognised that end of life care needed to be improved and had begun working towards this, but we found much more progress was needed. We were concerned about the safety and effectiveness of the mortuary arrangements at Royal Shrewsbury Hospital in that the maintenance of this area was poor and it could not cope with the current demands placed on the service.

We saw several areas of outstanding practice, including:

Summary of findings

- The trust had good safeguarding procedures in place. The safeguarding team had links in every department where children were seen, with safeguarding information shared across the trust.
- The trust had appointed an Independent Domestic Violence Advisor. The post had been supported through funding from the Police Crime Commissioner because of the excellent outcomes for people recorded by the trust. Referrals from the trust to the Multi Agency Risk Assessment Conference had been endorsed as excellent practice by Coordinated Action against Domestic Abuse (CAADA). CAADA a national charity supporting a multi-agency and risk-led response to domestic abuse.

We raised some of the urgent issues at the time of our inspection and the trust has taken action to address the equipment staffing needs within accident and emergency and critical care areas.

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

Importantly, the trust must:

- The trust must review the levels of nursing staff across A&E critical care and end of life services to ensure they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that further service development and learning can take place.
- Ensure that staff are able to access mandatory training in all areas.
- Ensure that accident and emergency and all surgical wards are able to access all the necessary equipment to provide safe and effective care.
- Review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.
- Ensure that mortuary services are safe through maintenance and security of this area.

There were also areas of practice where the trust should take action:

- Review the availability of support staff across the seven-day week to improve outcomes for patients.
- Review the achievements and actions taken to address the targets set nationally within A&E and across audits in medicine and in end of life care.
- Review the specific equipment required to support an effective service for those people living with dementia.
- Review medicines storage in surgery.
- Review the capacity and flow within surgery and critical care to reduce waiting times and improve services to patients.
- Review the provision of the end of life service to ensure that patients can access this service throughout the week.
- Review the communication between senior managers and staff to ensure that initiatives and issues are captured.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The accident and emergency department at Royal Shrewsbury Hospital provides a caring service but required some improvements in terms of safety, effectiveness, responsiveness and well led areas. When incident reports were completed, the hospital did have a clear 'lessons learnt' approach but staff did not consistently receive feedback on incidents. We looked at equipment, which was visibly clean but was not always maintained to the manufacturer's recommendations, with service labels highlighting that a service was due. During our inspection we noted limited availability of equipment. Audits were not always used to improve services within the department. Targets for meeting response times were also below the national standard and ambulance waiting times required improvement. Whilst the local team had experienced leaders there were gaps in risk management and improvements to services which could be reasonably addressed. Triage was effective and waiting times for this were kept to a minimum. We saw staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us they had all their questions answered and felt involved in making decisions about their care.
Medical care	Requires improvement 	Medical care at Royal Shrewsbury Hospital required improvement. Each ward displayed their safety data on a quality board but not all relevant data was included. The introduction of the quality boards had been welcomed by staff, but required embedding for a uniform approach across all the wards. On the whole we found the wards were clean, well maintained and tidy. However, in several ward areas we observed poor infection control techniques relating to cannula care. Policy and procedures were not being followed and this was brought to the ward manager's attention. Staff shortages were impacting on the wards performance. Ward staff were being supported on most shifts by agency and bank staff. Staff raised

concerns with us about the quality of some agency staff which they felt increased the pressure on them and had an impact on morale. Some ward managers but not all, had ensured that trained agency staff had completed the trust based competency tests. It had been acknowledged by the trust that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. There were currently three trust funded vacancies. Staff had not been released to attend mandatory training. Attendance levels for mandatory training were noted to be exceptionally poor in most areas in medicine; some as low as 5%. The trust had not promoted seven-day working and this was impacting on patient care and recovery.
We saw that the introduction of the Butterfly Scheme for care of patients with dementia had been initiated but this required further work to cascade to its full potential in all areas. Medical notes were stored in open trolleys, unsecure on the wards and we saw on the AMU the open medical notes trolley in the ambulatory care area was down the corridor completely unobserved by staff near the entrance very open to the public.
The trust was aware that safety thermometer data had shown a high number of pressure ulcers and falls recorded in medical care. There was evidence that actions had been taken to reduce harm. We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy. Patients we spoke with were complimentary and full of praise for the staff looking after them.

Surgery **Requires improvement**

Patients were not adequately protected from avoidable harm as medical records were not stored correctly. We were concerned that patients received care on a ward with no heating and where the emergency alarms were deficient. The trust took immediate action to rectify these findings. Services were not always effective because of out of date care pathways, lack of competency assessments and lack of physiotherapy services for patients with fractured hips.
We saw many instances of good care, but we also saw a number of poor care practices and a senior member of staff told us they did not always have

Summary of findings

time to explain things to patients. Surgical services were not responsive; they struggled to meet treatment times, some patients were kept in recovery for long periods while waiting for a bed, and not all patients could use the bathing facilities. Not all staff could explain a vision for the service they worked in, they felt under pressure and were not always supported by senior management. Governance arrangements meant that the service was not well led.

Critical care

Requires improvement

Critical care services were found to require improvement overall. The critical care service staff were caring and compassionate and we judged that this domain was good.

There were not enough suitably skilled and experienced staff on the unit, which represented a significant risk to patients. When we highlighted the staffing shortfalls to the trust they took immediate action to ensure that sufficient and appropriate nursing staff were available to care for patients in ICU and HDU.

Critical care services were obtaining good quality outcomes, and patients received treatment that was based on national guidelines. The general capacity of beds in the hospital was a challenge. Bed capacity had also impacted on critical care services both in the availability of the beds within critical care and also delays in discharging patients to other wards.

The trust had two small critical care units and found it difficult to ensure that sufficient and suitably experienced medical and nursing staff for both units were available. There are plans to review the critical care services that are provided by the trust to ensure that safe and effective care and treatment are provided.

Improvements were required to the leadership of the critical care services, to ensure that the management responded appropriately to staff and that the service provided met national core standards.

Maternity and gynaecology

Good

The consultant-led unit had recently moved to Princess Royal Hospital because Royal Shrewsbury Hospital did not comply with structural building standards, the trust had deemed it unsuitable for long-term use.

Summary of findings

We saw that the MLU was well staffed and women were very satisfied with the care that they had received. Staff knew how to report incidents but felt feedback could be improved. They had access to all the necessary equipment and felt well supported by their managers. The unit regularly audited its services to ensure they were effective and there was good multidisciplinary working. Staff were very caring and were able to respond to individual needs. Staff were not aware of a vision for the service beyond the recent restructure and the reporting of some performance data could be clearer.

Services for children and young people

Good

Services for children and young people were found to be good. Children received good care from dedicated, caring and well-trained staff who were skilled in working and communicating with children, young people and their families.
The trust had robust arrangements in place to monitor incidents and staff were clear on their responsibilities relating to this. Children who were seriously ill were appropriately escalated for specialised care and this might involve transfer to Princess Royal Hospital at Telford.
Staff were up to date with mandatory training and robust governance arrangements were in place for children and young people's services and staff were clear on their roles and responsibilities. Staff felt valued and had clear lines of communication through the trust. Staff felt confident in raising concerns and felt listened to regarding ideas to improve services

End of life care

Inadequate

End of life care required improvements in all areas except for safety, which was inadequate, and caring, which was good. The service was not safe because the mortuary environment and equipment within the mortuary were inadequately maintained. The environment was old and the fridges where deceased patients were kept regularly malfunctioned, which could affect the preservation of the bodies. The storage capacity within the service was also insufficient to cope with increased demand.
End of life services required improvement in effectiveness because the trust-developed end of life care plan had not been rolled out for use

Summary of findings

trust-wide at the time of our inspection. The trust did partake in the National Care of the Dying Audit 2014 and performed worse than the England average on five out of seven organisational indicators and all clinical key performance indicators.

The service was not responsive because there was no formal strategic plan for the delivery of end of life care within the trust. There were also no designated beds for providing patients with palliative care. The viewing room for children in the mortuary was not responsive. The room was small and not welcoming and to view children in this room could be considered uncaring towards bereaved families. The layout of the renal dialysis unit was not responsive. Patients coming in for their daily treatment had to walk through the acute inpatient area.

The service was not well led. On an individual level people were well cared for and locally those providing end of life care within departments led the provision of this well. However, we found that there was oversight by senior management and members of the executive team with regards to end of life care that required improvement.

Staffing levels of nurses and medical staff in palliative care were not sufficient to reach all patients who may have benefitted from their expertise. Staff were not provided with mandatory training in end of life care.

Outpatients and diagnostic imaging

Good

Overall we rated this service as good. Outpatients and diagnostic imaging services were safe. The trust had prioritised statutory training, but refresher mandatory training had not been completed by the majority of staff. Mandatory training was provided at the trust's discretion and to ensure compliance with local standards and policies. This meant that the trust could not be confident that staff were following the most recent advice and guidance.

We saw good practice and effective, compassionate care. Patients were very complimentary about all the staff they had come into contact with. Staff were observed to be caring and compassionate in the

Summary of findings

way they dealt with patients and their families or carers. They were knowledgeable and enthusiastic about the service they provided and this was reflected in how they engaged with people.
We saw good practice and some innovative working and interpretation of NICE guidance to the benefit of patients and the trust. Services were managed well at a local level; appraisals and supervision of practice were completed. Meetings took place between staff and managers. Staff felt supported and they told us they respected their managers.

Requires improvement

Royal Shrewsbury Hospital

Detailed findings

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

Contents

Detailed findings

Background to Royal Shrewsbury Hospital

Royal Shrewsbury Hospital was formed in 1979, after the merger and closure of a number of hospitals in the town. Royal Shrewsbury Hospital merged with Princess Royal Hospital in Telford in 2003, when Shrewsbury and Telford Hospital NHS Trust was formed.

The hospital provides a wide range of acute hospital services, including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Royal Shrewsbury Hospital is also the main centre for acute and emergency surgery, and has a trauma unit that is part of the region-wide network. It is the main centre for oncology and haematology.

The trust has a relatively new executive team. The finance director has been in post since 2011, the chief executive and chief operating officer since 2012, and the director of nursing and medical director are the most recent appointments in 2013. The chair has also been in post since 2013.

Shrewsbury and Telford Hospital NHS Trust has been inspected 11 times since its registration with the CQC in April 2010. Royal Shrewsbury Hospital was last inspected in October 2013 and was found to be non-compliant with a number of the Essential Standards and had compliance actions to continue to improve. We reviewed these as part of our inspection and found that previous compliance actions had been met. However, we have issued further compliance actions at a trust level because breaches of the regulatory requirement placed upon hospitals in relation to safety and quality were found at both hospitals.

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this trust because it represented a risk in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, the trust was considered to be a high-risk service.

The inspection team inspected the following eight core services:

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

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing and Patient Experience, Royal Surrey County Hospital NHS Trust

Team Leader: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team of 35 included CQC inspectors and a variety of specialists: medical consultant, surgical consultant, consultant obstetrician, consultant paediatrician, consultant anaesthetist, junior doctor, board level nurses, modern matrons, specialist nurses, theatre nurses, emergency nurse practitioner, a supervisor of midwives, student nurses and a paramedic and four experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Detailed findings

- Is it well led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the two local Healthwatch organisations.

We held a listening event in Shrewsbury on 14 October 2014, when people shared their views and experiences of both hospitals. Some people who were unable to attend the listening events shared their experiences by email or telephone.

We carried out an announced inspection visit 14 - 16 October 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also carried out an unannounced inspection on 27 October 2014 of maternity, accident and emergency, critical care and surgery.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Shrewsbury and Telford Hospital NHS Trust.

Facts and data about Royal Shrewsbury Hospital

The annual turnover (total income) for the trust was £314 million in 2013/14. The trust surplus (deficit) was £65,000 for 2013/14.

Royal Shrewsbury Hospital has around 500 beds across 44 wards and employs over 2,500 staff.

During 2012/13 Royal Shrewsbury Hospital had 46,751 inpatient admissions, 321,840 outpatient attendances and 53,419 attendances in the emergency department. Between May 2013 and April 2014 4,721 babies were born at the hospital.

Bed occupancy for general and acute care was 90.4% between April and June 2014. This was above both the England average of 87.5%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. Adult critical care was also higher than the England average; 90% against the average of 85.7%. Maternity was at 55% bed occupancy – lower than the England average of 58.6%.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

<Notes here>

Urgent and emergency services

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

Information about the service

The accident and emergency department (A&E) at Royal Shrewsbury Hospital provides a 24-hour, seven-day a week service to the local area. The department saw 53,419 patients between April 2013 and March 2014.

Patients present to the department either by walking in through reception or arriving by ambulance. The department had facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's A&E service.

Our inspection included two days in the A&E department as part of an announced inspection. During our inspection, we spoke with clinical and nursing leads for the department. We spoke with five members of the medical team (at various levels of seniority), 11 members of the nursing team (at various levels of seniority), including the lead nurse for safeguarding children and adults. We also spoke with 15 patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department.

The trust has consistently not met the national target for treating 95% of patients attending A&E within four hours and performance with regards to the four-hour waiting times has been consistently below the England average waiting time between April 2013 and August 2014.

The A&E department is a member of a regional trauma network.

Summary of findings

The accident and emergency department at Royal Shrewsbury Hospital provides a caring service but required some improvements in terms of safety, effectiveness, responsiveness and well led areas. When incident reports were completed, the hospital did have a clear 'lessons learnt' approach but staff did not consistently receive feedback on incidents. We looked at equipment, which was visibly clean but was not always maintained to the manufacturer's recommendations, with service labels highlighting that a service was due. During our inspection we noted limited availability of equipment.

Audits were not always used to improve services within the department. Targets for meeting response times were also below the national standard and ambulance waiting times required improvement. Whilst the local team had experienced leaders there were gaps in risk management and improvements to services which could be reasonably addressed.

Triage was effective and waiting times for this were kept to a minimum. We saw staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients told us they had all their questions answered and felt involved in making decisions about their care.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Services to maintain patients' safety required improvement. We saw that staffing levels were not sufficient within the treatment areas. Staff were aware of the challenges within the department regarding service provision against demand and were working towards addressing those challenges. We identified some concerns about the equipment available in the majors treatment area. We spoke with two members of staff about the availability of resuscitation equipment such as portable defibrillators. They told us that there were no defibrillators in the majors treatment area and that, if one was needed, it would be taken from the resuscitation area. This meant that there was a risk to patients because of the lack of availability and accessibility of equipment needed in emergency situations.

The department had a number of systems and processes in place to protect patients and assist staff. There were treatment pathways, a triage process in the minors treatment area and an escalation process for reporting incidents and concerns about staffing and capacity. We saw that the A&E department had systems in place to identify risks to people who used the service. People identified as having a risk were assessed and their safety was monitored and maintained through the staff's use of early warning tools.

Incidents

- The trust reported eight serious incidents relating to both Royal Shrewsbury Hospital and Princess Royal Hospital to the National Reporting and Learning System and The Strategic Executive Information System relating to the A&E departments between March 2013 and March 2014. This included four serious incidents involving delays in diagnosis at Royal Shrewsbury Hospital.
- We asked staff if they reported incidents and had knowledge of the reporting system. Staff told us that they reported incidents using the hospital internal reporting system, but not all staff who reported incidents received individual feedback on outcomes and closure on incidents they personally reported.
- We spoke with senior nursing staff who told us about evidence of learning from incidents. For example, there had been a change within the patient handover process that now involved the handover at the patient's bedside. This had reduced any miscommunication about the patient's care.

Cleanliness, infection control and hygiene

- During our inspection we observed limited personal protective equipment practice; not all staff were witnessed to be wearing gloves or washing their hands between patients. We informed the manager about this during our inspection and each member of staff was spoken to and advice given on best practice in infection prevention and control.
- Treatment rooms were deep cleaned after any patient with a queried infection was admitted to another area or discharged.
- The trust's infection rates for Clostridium difficile and MRSA infections were within a statistically acceptable range for the size of the trust.
- We noted during our inspection that there was hand cleaning stations within treatment areas. Hand sanitizer was found at each door entrance and was full. We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over and we could not see a specific area identified for this activity.
- We looked at all areas of the department during our inspection and found them to be visibly clean and bright. Clinical waste bins were available, but not all sections on bin labels were completed by the person who assembled the clinical waste bin, such as the date when the bin was assembled and the name of the person who assembled it. This is a requirement under current legislation so that waste can be identified and traced if necessary.
- The A&E department had its own dedicated team of cleaners who followed a weekly schedule. We spoke with cleaning staff who told us that they enjoyed working in the same area rather than all over the hospital because it gave them a sense of ownership and pride in the department. This allowed consistency with regards to keeping the schedule up to date.

Environment and equipment

- The resuscitation area was visibly clean and bright. Resuscitation equipment was available and clearly

identified. Equipment trolleys followed a system that adopted airway, breathing and circulation management approach within each resuscitation bay. There was a specific children's equipment trolley.

- During our inspection we did note that there was no resuscitation trolley within the major's treatment area. When we asked about this, we were told that a trolley would be obtained from the designated resuscitation room which could delay the availability of equipment in an emergency in the majors area. We re-visited this area during our unannounced inspection and saw that resuscitation trollies were available within the major's area.
- Treatment cubicles were visibly clean and bright; However, there was limited equipment available in each cubicle and we saw that nursing and medical staff often had to share equipment with other cubicles. This equipment included heart activity recording equipment and blood pressure monitoring equipment. This meant that tests were at times delayed. The trust had plans in place at our unannounced inspection to ensure that this equipment was provided.
- We looked at various pieces of equipment across all areas within the A&E department. We found inconsistency with regards to scheduled servicing, with some pieces of equipment being a year out of date from the recommended service. This was identified through the trust's internal service stickers on each piece of equipment. This could mean that faulty equipment was used for patient care.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription charts, which were completed and signed by the prescriber and by the nurse administering the medication.

Records

- We looked at seven sets of A&E clinical notes during our inspection.
- All of the notes we looked at had completed observations taken with regular re-assessment that were recorded.
- During our inspection we observed that A&E notes were kept safe and secure. Notes were clearly defined between clinical observations and nursing/medical notes.
- We saw within the A&E notes that risk assessments were undertaken in the department when patients were in the department for some time (the Royal College of Nursing recommends that a risk assessment for falls and pressure ulcers should be completed if patients are in an area for longer than six hours).
- We saw within records that every patient, despite their age, had a Waterlow body map completed (the Waterlow score or Waterlow scale gives an estimated risk for the development of a pressure sore in a given patient).

Safeguarding

- The A&E department had a safeguarding lead within the department who was knowledgeable and demonstrated underpinning knowledge of both safeguarding children and vulnerable adults.
- We looked at training records and saw that all nursing and medical staff had undergone mandatory safeguarding training to an appropriate level.
- All safeguarding concerns were raised through an internal paper-based reporting system. If the safeguarding lead was not available, then a telephone message was left. The concerns were reviewed by the safeguarding lead when they were available and at a senior level to ensure a referral had been made to the local authority's safeguarding team.
- The staff we spoke with were aware of how to recognise signs of abuse and the reporting procedures in place within their respective areas.

Mandatory training

- We were provided with comprehensive records of mandatory and supplementary training for all nursing and medical staff. Whilst most nursing staff had completed mandatory training (88%) only 44% of doctors had completed this type of training.
- Mandatory training was provided in different formats, including face-to-face classroom training and E-learning (E-learning is electronic learning using a computer system), although staff told us that there was limited time allowed to complete extra training.

Urgent and emergency services

Management of deteriorating patients

- We observed that the department operates a triage system for patients presenting to the department either by themselves or by ambulance, and are seen in priority according to their condition.
- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert) so that an appropriate team are alerted and prepared for their arrival.
- We looked at a pre-alert form for a pre-alert that occurred during our inspection and found that the forms had been completed fully with any clinical observations recorded, estimated time of arrival of the ambulance to the A&E department and who took the details over the telephone from the ambulance service.
- Nursing handovers were comprehensive and thorough, covering elements of general safety as well as patient-specific information.
- The A&E department operates a national Early Warning Score (NEWS) alert system to monitor the condition of patients and alert staff to any changes. The NEWS system is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in, hospital.

Nursing staffing

- Information provided by the trust indicated that the establishment for the A&E department was not operating at the required whole time equivalents. Vacancies were measured in percentages of whole time equivalent posts and data showed the following vacancies; 8% band 2-4, 10% band 5-6 and 16% band 7 and above. Senior staff acknowledged that they were not meeting the RCN 'BEST' policy to understand their staffing needs and they were actively looking at this policy.
- We looked at the nursing rota and saw that the department was often short staffed on a daily basis. The department should operate at a whole time equivalent of 52.3 staff in post. We saw that the department had a 44.5 whole time equivalent nursing staff.
- We saw that a recent skill mix review had taken place and, although the skill mix request was authorised, it had not been put into place within the department.
- The department did not have sufficient whole time equivalent nurses with specific paediatric qualifications working within the paediatric A&E. When they were on shift, they would be assigned to the paediatric service within A&E and would be supported with other nurses.
- We observed that there was a professional handover of care between each shift.
- The A&E department is very reliant on bank and agency staff, which can pose a risk to safety through staff not being aware of hospital policies and variable competency of these members of staff . However, these staff received local induction before starting their shift, but competency varied between nursing agencies.

Medical staffing

- 23% of medical staff are consultants, this is in line with the England average.
- Consultant grade doctors are present in the department from 8am until 8pm seven days a week. There are middle-grade doctors and junior doctors overnight with an on-call consultant system.
- The department regularly employed locum middle-grade doctors. When we reviewed the rota we noted that the same doctors were consistently in use. Doctors had received the trust induction programme and were familiar with the department and protocols.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We found that the A&E department was performing below the national average in the College of Emergency Medicine audits and did not appear to be using this to improve services within the department. However the A&E used evidence-based guidelines – for example, there were a number of care pathways in the department for patients with specific conditions, such as the stroke and sepsis pathways.

The department took part in national College of Emergency Medicine audits. The majority of results were worse than other trusts and the results had not been used to assess the effectiveness of the department.

Urgent and emergency services

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidance. They told us that, as NICE guidance was issued, they made sure that any relevant to the A&E were implemented and that staff were aware of the requirements. NICE guidance was discussed at governance meetings that senior staff attended.

Evidence-based care and treatment

- Departmental policies were easily accessible, and staff were aware of and reported they used them. There was a range of A&E protocols available that were specific to the A&E department.
- Further trust guidelines and policies were within the A&E department. For example, sepsis and needle stick injury procedures. We saw treatment plans, which were based on the NICE guidance.
- We found reference to the College of Emergency Medicine standards and spoke with medical staff who demonstrated knowledge of these standards.

Care plans and Pathways

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six was the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- Nurses in the A&E at Royal Shrewsbury Hospital did not obtain blood from patients who were query septic; doctors obtained these blood samples. This meant that the process was reliant on a doctor being available and the care pathway could be delayed with regards to antibiotic treatment.
- We spoke with staff who were knowledgeable about the care pathways available to patients and the appropriateness of each pathway.

Nutrition and hydration

- The department did not provide regular food and drink 24 hours a day, seven days a week. It was observed during our inspection that if patients required something to eat or drink, they had to find a nurse and ask if they could have something.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured the patient was safe and then undertook a mental capacity assessment.
- According to the A&E mandatory training database, all nursing and medical staff had undergone mental capacity training.
- We observed nursing and medical staff gaining consent from patients before any care or procedure being carried out.

Patient outcomes

- We were informed that the department took part in national College of Emergency Medicine audits. The majority of results were worse than other trusts and within the lower England quartile. We could not see evidence that the results had been used to improve the effectiveness of the department. There was a lack of action plans which addressed the findings of audits in order to improve services.
- The College of Emergency Medicine recommends that the rate of unplanned re-admittance within seven days for A&E should be between 1 and 5%. The national average for England is around 7%. The trust had performed better than the average since January 2013. Their rate in May 2014 was 5.5%.

Competent staff

- 78% of appraisals of nursing grades were undertaken and staff spoke positively about the process and that it was of benefit.
- We spoke with nursing staff who told us that they felt mandatory training was delivered and kept them up to date, but that clinical supervision could be better and was thought of when the need arose rather than on a regular basis.
- We saw records that demonstrated 100% of medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- One senior doctor told us that they found it difficult to access training to make sure they were up to date with their current practice and had to complete this in their own time because of pressures within the department.

Multidisciplinary working

- We witnessed comprehensive multidisciplinary team working within the A&E department. Medical and nursing handovers were undertaken separately. Nursing handovers occurred twice a day.

Urgent and emergency services

- There was a five-minute handover, where staffing for the shift was discussed as well as any high-risk patients or potential issues. A further patient handover was held at the patient's bedside making the patient the centre of care. Medical handover occurred twice a day and was led by the consultant on the A&E floor.
- Staff we spoke with were aware of the protocols to follow and key contacts with external teams. We witnessed a professional patient experience from transition from the care of the ambulance service to the A&E staff.
- The department held monthly clinical governance meetings where mortality and morbidity is one item on a regular agenda. Both clinical and nursing staff attended these meetings.

Seven-day services

- There was a consultant out-of-hours service provided through an on-call system.
- A&E offered all services where required seven days a week.
- We were told by senior staff within the A&E department that external support services are limited out of hours and are difficult to obtain at weekends which has an effect on patient discharges and care packages.

Are urgent and emergency services caring?

Good

Evidence provided to our inspection and from speaking to patients provided us with sufficient assurance that the department at Royal Shrewsbury Hospital was providing a consistently caring service.

The department had worked hard to increase the Friend and Family Test response rate. During our inspection we saw Friends and Family questionnaires displayed within the treatment and reception areas.

We saw many episodes of caring interaction during our visit and feedback from individual patients and relatives was universally positive.

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring, compassionate attitudes towards patients.
- During our inspection we saw that staff responded in a timely manner to patients who requested help or required assistance.
- Staff we spoke with demonstrated an understanding of the need to recognise cultural, social and religious individual needs of patients.
- We saw that staff were respectful and that they maintained confidentiality around patients and relatives when communicating with external and internal departments, ensuring that people's information was protected.
- The trust can be seen to be performing above the England average for the Friends and Family Test, which is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family Test highlights both good and poor patient experience. Figures demonstrated that between April 2013 and July 2014, the Friends and Family Test score for the A&E department was an average of 65; the highest score of 80 was in May and June 2013.

Patient understanding and involvement

- Patients told us they felt informed about their patient journey and that staff were responsive. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was and how long they would have to wait to be seen.
- The people in the minors treatment area told us that their treatment was discussed with them. They were aware of the options for the next stage of their patient journey. We spoke with people in the majors treatment area who were always clear what was happening to them or whether they were able to make choices about the treatment they received.

Emotional support

- We witnessed staff providing patients and relatives with emotional support, and staff demonstrated they understood the impact of treatment on a person's wellbeing. For example, we saw a nurse take their time to ensure that a patient who was being admitted had the opportunity to inform their family about their admission.

Urgent and emergency services

- Staff tried to support patients and their relatives as much as they could in the time they had, but staff were very busy during our inspection and were therefore unable to spend a lot of time with people. Patients and relatives thought that the staff were helpful if they were approached.
- We saw that people's independence was respected and supported, which enabled people to manage their own health, care and wellbeing.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Trusts in England were tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. Shrewsbury and Telford Hospital NHS Trust was consistently not meeting this target. The trust had struggled to maintain the 95% target and had been below the England average many times during the period from August 2013 to August 2014, the lowest rate being 88% in January 2014.

The escalation protocol was sufficient and provided a safe response. For example, patients waiting more than 15 minutes within the ambulance triage area had observations taken and a dynamic triage took place with care provided.

There were regular occurrences of ambulances queuing and waiting to hand over within the department. But the department has a good working relationship with the local ambulance service and took a pro-active approach to managing these occurrences, with the ambulance service attending the department in support.

Patients who had been in A&E overnight told us that they were not routinely offered drinks or snacks. However, one person who had been admitted to the department overnight had not been offered food and a drink until transferred to the ward at lunchtime the following day.

Service planning and delivery to meet the needs of local people

- The emergency department has an escalation policy that was developed by the management team. We were told the escalation policy was put in place for when the department was experiencing long delays in ambulance handovers, patients being transferred to a ward and including a lack of available beds within the hospital to admit patients. The policy details what steps to take, for example, extra staff to be moved into the department, including porters.
- During periods of demand, the department started to struggle. There was clear coordination within teams, which enabled patient flow through the department to be safely maintained. We witnessed delays in senior medical speciality reviews, in particular for orthopaedic patients.
- The department coordinated and delivered care that took account of people with complex needs. For example, we saw that the department had champions who led on specific areas to help with individuals' needs, including learning disabilities, mental capacity and dementia.
- The department had limited space that restricted growth, and there was a growing population for the services that were delivered.

Access and flow

- The department operates a triage system of patients presenting to the department either by themselves or by ambulance, and patients are seen in priority according to their condition.
- The trust is performing below the England average with regards to handover of patient care from the ambulance crew to the A&E department, and there are consistent long ambulance delays with waiting times over 30 minutes.
- The trust has struggled to maintain the 95% target of patients being seen within four hours of arrival. For most months in 2013/2014 the trust was well below the national average and has only hit the target in 11 weeks. The lowest rate was 88% in January 2014.
- There was an internal 'live' electronic system to evaluate and manage patient flow through the department to assist with bed demand across the hospital and this was monitored by the designated shift coordinator.
- The trust was performing worse than the England average for the percentage of emergency admissions

through the A&E department waiting 4–12 hours between the decision to admit and being admitted. In February 2014 the trust was performing at 22%, the England average being 6%.

Meeting people's individual needs

- We observed that it was difficult to maintain a patient's privacy because of ambulance crews waiting to hand over another patient and no ability to hand over confidential information. The ambulance handover area was inadequate in these aspects.
- Porters told us that they had not received any training about how to work with patients living with dementia, who they often had to move from the A&E to wards.
- Patients in A&E were not routinely offered food or fluids despite being in the department for prolonged periods.

Learning from complaints and concerns

- The A&E department advocates the Patient Advice and Liaison Service, which is available throughout the hospital.
- Information was available for patients on how to make a complaint and how to access the Patient Advice and Liaison Service.
- All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was disseminated to the whole team in order to improve patient experience within the department. Complaints were analysed at the root cause and we were told that the amount of complaints about A&E services had dropped within the previous 12 months (September 2013 to September 2014). This was due to having an open culture within the department of ownership and openness to create an environment of 'no blame'.
- We asked staff whether they received information about complaints and concerns. They told us that they were regularly informed about them. They told us that lessons learned were discussed at team meetings with two-way feedback.

Are urgent and emergency services well-led?

Requires improvement

The leadership within the A&E department was experienced enough to ensure good patient experience and flow through the department. However, management changes that happened throughout the whole department created an insecure feeling that affected staff morale.

There was not an acceptance of change and staff told us that it took a long while to be accepted in the department. The staff we spoke with demonstrated an attitude of commitment but the morale was low.

We spoke with nurses, healthcare support workers, porters, junior doctors and consultants to find out about the culture of the department. We saw that staff were clear about their roles and accountability.

We were not reassured that risks were well managed within the department. Managers were aware of the risks identified but there was no robust timeline of actions to address each risk.

The department managers understood the challenges to identify and provide good quality care but struggled to deliver the actions required at times of high demand.

Vision and strategy for this service

- Not all staff who we spoke with were knowledgeable about the vision for the service. They were not always aware of the problems concerning the department's priorities.
- Information was not always available to all staff in different formats about the trust's vision and strategy. There was limited information giving updates on any changes or amendments to the department's priorities and performance against those priorities.
- The department lacked vision in the promotion of best practices across both A&E departments. The two A&E departments worked very differently, but best practice would involve streamlining and improving patient experience. For example, the initial triage system for walking patients is two different systems within one trust.

- The future vision of the department was not embedded within the team and was not well described by all members of staff.

Governance, risk management and quality measurement

- Monthly departmental meetings were held. We were provided with minutes of the meetings held over the past six months. We were not reassured that risks were well managed within the department. Managers were aware of the risks identified but there was no robust timeline of actions to address each risk.
- There was a set agenda for each of these meetings with certain standing items. For example, incidents, complaints, risk, staffing and training.
- A quality dashboard was not displayed within the A&E department at Royal Shrewsbury Hospital. This meant that people who used the service and staff were not aware of the department's performance on the care being received or delivered.
- We spoke with staff about quality indicators and there was a lack of demonstrable knowledge; some senior staff were unable to provide an example of a quality clinical indicator or a performance indicator. This meant that staff were not aware if clinical care provided was of a good quality and measurable against national figures.

Leadership of service

- There was a clear departmental team, which was respected and led by the senior nurses.
- Staff told us they did not feel supported by the senior executive trust management team. They told us that the nursing leadership in the department was good. When the A&E was under pressure, the department didn't always receive the support and leadership it needed.
- During our inspection we saw that the departmental leadership strived to provide an environment whereby learning and progression was encouraged. However, financial pressures compromised the leadership of the service with the inability to release staff to work on projects and initiatives to promote the services available to people.

Culture within the service

- Most staff told us that there was a sense of team working within the department. They thought that the team pulled together in difficult times and supported each other. Some staff, however, told us that they felt under pressure to meet targets and were made to feel as though they had failed to do their job correctly by senior managers waiting time targets were not met.
- A senior manager told us that they were aware of the problems with stress in the A&E. The senior manager told us they were unaware of any action taken to address staff stress levels. When we checked with the human resources department, we were told that no practical action had been taken to try to reduce staff stress

Public and staff engagement

- There were a number of trust-wide initiatives in place to increase engagement with staff. Staff in A&E did not feel engaged outside of the department and demonstrated little awareness of the various initiatives taking place across the trust. One member of staff told us that they just didn't have time to get involved in things when they were working. Some staff felt that they were not listened to. For example, when they made suggestions to the trust about how to improve the department.
- During our inspection we did not see any information available to people who use the services for participation and involvement so that their views could be reflected in the planning and delivery of services provided within the A&E department.

Innovation, improvement and sustainability

- We saw evidence of individual staff innovation that was put into practice and owned by the department as a team effort. For example, a nurse had personally identified an area of improvement for a children's waiting area for which they raised funds and decorated appropriately in their own time to provide comfort to children using the service.
- We spoke with a senior manager within the trust about how lessons learned from incidents were communicated across the trust. They told us that they would expect senior staff to pass this information to the rest of the team, but they said there was no mechanism in place to check that this was happening.

Medical care (including older people's care)

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

Information about the service

The Royal Shrewsbury Hospital (RSH) provided services for elderly care, stroke and rehabilitation, oncology and haematology, cardiology, endocrinology, respiratory, nephrology and gastroenterology. The therapy services provided a day service including speech and language, physiotherapy, occupational therapy and dietetics. There were 182 inpatient medical beds available.

Patients were admitted to the acute medical unit (AMU) on a short stay basis after direct referral from their GP or from the Emergency Department. Patients were either discharged directly from AMU or transferred to a specialised ward within the hospital.

We visited seven wards and the acute medical unit. We spoke with 27 patients and 21 staff. We observed staff interacting with patients on the wards.

Summary of findings

Medical care at Royal Shrewsbury Hospital required improvement. Each ward displayed their safety data on a quality board but not all relevant data was included. The introduction of the quality boards had been welcomed by staff, but required embedding for a uniform approach across all the wards. On the whole we found the wards were clean, well maintained and tidy. However, in several ward areas we observed poor infection control techniques relating to cannula care. Policy and procedures were not being followed and this was brought to the ward manager's attention.

Staff shortages were impacting on the wards performance. Ward staff were being supported on most shifts by agency and bank staff. Staff raised concerns with us about the quality of some agency staff which they felt increased the pressure on them and had an impact on morale. Some ward managers but not all, had ensured that trained agency staff had completed the trust based competency tests. It had been acknowledged by the trust that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. There were currently three trust funded vacancies.

Staff had not been released to attend mandatory training. Attendance levels for mandatory training were noted to be exceptionally poor in most areas in medicine; some as low as 5%. The trust had not promoted seven-day working and this was impacting on patient care and recovery.

Medical care (including older people's care)

We saw that the introduction of the Butterfly Scheme for care of patients with dementia had been initiated but this required further work to cascade to its full potential in all areas. Medical notes were stored in open trolleys, unsecure on the wards and we saw on the AMU the open medical notes trolley in the ambulatory care area was down the corridor completely unobserved by staff near the entrance very open to the public.

The trust was aware that safety thermometer data had shown a high number of pressure ulcers and falls recorded in medical care. There was evidence that actions had been taken to reduce harm. We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy. Patients we spoke with were complimentary and full of praise for the staff looking after them.

Are medical care services safe?

Requires improvement

Medical care services required improvements to prevent patients from avoidable harm. The high number of medical and nursing staff vacancies was impacting negatively on staff wellbeing, morale and limiting access to mandatory training. The high use of agency staff meant that substantive staff were under pressure to supervise temporary staff and were unable to be released from the wards. Staff reported that on occasions when they did attend training it had been cancelled due to overall low staff attendance. Mangers in the service recognised this as a key area of concern. The average turnover of staff for medicine was 11.78% which was worse than the trust average.

Medical notes were stored in open trolleys, unsecure on the wards and we saw on AMU the open medical notes trolley in the ambulatory care area was down the corridor completely unobserved by staff near the entrance very open to the public. Resuscitation trolleys were accessible on each ward. Three had not been checked and signed as 'in order' on a daily basis, as per trust policy. This was brought to the ward manager's attention. Infection control issues were identified regarding cannula care; on several occasions we observed the trust policy and procedure not being followed.

Incidents

- Serious incidents were investigated through a root cause analysis process and an action plan for improvement was developed; 35 serious incidents were reported for Royal Shrewsbury Hospital.
- There were 43 serious untoward incidents reported to the Strategic Executive Information System for Royal Shrewsbury Hospital. The majority related to grade three or four pressure ulcers and falls with harm. The trust reports avoidable and unavoidable pressure ulcers on this system for transparency.
- Trust-wide learning was shared through the clinical governance executive committee and through tools such as the safety bulletin, INJEKTION, a new publication in which staff were proud to demonstrate areas of improvement through learning from incidents.

We did not see evidence of this bulletin at Royal Shrewsbury Hospital, which supported the reports of different systems in use across the service and throughout the trust.

- Staff told us they were aware of how to report incidents and were encouraged to do so, using the Datix system, but on occasions they did not get any feedback which did not promote learning.
- The trends that were highlighted through care audit results were monitored and action taken to improve any issues that were identified. For example, hand hygiene compliance had improved in all areas. Staff were observed and spot checked by the ward sister to ensure that they were following the trust's hand hygiene policy.
- Doctors told us they rarely reported incidents but that nurses reported any incidents that they may have been involved with.
- Matrons told us they were encouraged to attend the mortality and morbidity meetings relevant to their area and they then fed back to the ward staff involved.

Safety thermometer

- The trust monitored its performance through the NHS Safety Thermometer. This survey tool measured progress in providing a care environment free of harm for patients. The data was displayed in the ward areas for patients and staff to see, but it only included the previous month's performance and no trend data was displayed.
- We looked at the trust safety thermometer. The trust were aware that the safety thermometer had shown a high number of pressure ulcers and falls recorded in medicine. Effective action had been taken to reduce patient harm and the overall trajectory showed an overall positive trend in a marked reduction.
- The trust aimed to reduce all patient falls and falls causing harm in 2014/15. To support this, 'Fall Safe' risk assessments had been introduced to all wards, a link worker programme had been developed for supporting the prevention of falls and an updated information leaflet for staff and patients had been distributed.
- Additionally, progress had been made with support offered from the newly appointed falls prevention practitioner and dementia project lead nurse. Examples of this were the effective use of hi-lo beds and other relevant equipment, an increased awareness of falls prevention methods and additional education and support for wards with patients at high risk of falls.
- All grade two pressure ulcers were reviewed to prevent potential progression to grade three. The tissue viability team had been expanded to improve education and training. The pressure ulcer prevention plan had been amended to improve the recognition and classification of pressure ulcers. The quality and specification of all static and specialist mattresses and equipment that could contribute to pressure ulcers had been reviewed. An example of this was a new oxygen mask introduced to reduce the risk of pressure ulcers found on ears and noses. We observed patients being assessed for equipment that would relieve pressure.
- We were told that over the past 12–18 months significant effort had been made to ensure FRASE assessments were accurately completed in a timely manner and that relevant actions were considered and implemented.
- We reviewed the records of patients who had fallen whilst on the wards. We noted that of the two Patients were risk assessed using the Fall Risk Assessment Score for the Elderly (FRASE). We heard of significant effort being made by the staff to ensure FRASE assessments were completed in a timely manner. We were told that the accuracy of FRASE assessments had improved
- The CQUIN relating to reduction of venous thromboembolism (VTE) was met. The proportion of adult inpatients who have a VTE risk assessment on admission to hospital was appropriate and the completed root cause analysis confirmed cases of pulmonary embolism deep vein thrombosis.
- The target to reduce avoidable death, disability and chronic ill health from VTE was met, with 90% of admitted patients having a VTE assessment every month.

Cleanliness, infection control and hygiene

- Bare below the elbow signs and hand gel dispensers were seen at the entrance to wards. Hand washing facilities and hand gel was sited through the ward areas.
- We saw staff adhere to trust policies for hand hygiene, personal protection equipment and isolation.
- Weekly hand hygiene audits were undertaken and the trust wide results were displayed on the quality board. These ranged from 25% to 100% compliance. Where results were low, the ward manager completed further spot checks and observations of staff.
- In several areas we observed poor infection control techniques relating to cannula care. Policy and

procedures were not being followed and this was brought to the ward manager's attention. The ward manager spoke with the staff concerned and assurance was given that all staff would be reminded about following the trust's policy and procedure.
- The trust's infection control team worked with wards and medical teams to support compliance with sampling, cleanliness and prescribing of antimicrobial medicines.
- There had been four cases of C. difficile and no cases of MRSA reported at Royal Shrewsbury Hospital between April and September 2014.

Environment and equipment

- We saw that patient areas were free from trip hazards to ensure patient safety. Wards appeared tidy and organised.
- Equipment was replaced in a prioritised way through the risk register.
- We saw resuscitation equipment in all ward areas. These units were unlocked and accessible. Daily checks were signed on most days but not all days. The absence of some checks was brought to the attention of the particular ward managers.
- Within the renal unit we found that the service did not have any piped supplies of oxygen or suction; portable items were available. The lack of piped supplies could potentially place people at the risk of harm through supplies not being available. This risk was known to the service and trust and it was on the risk register.
- On the renal dialysis unit a small surgical procedures room was identified; in the event of an emergency staff acknowledged that manoeuvring around the patient's bed proved difficult. We found that there were no emergency call bells, piped oxygen, suction or emergency drugs available near this room. We escalated our concerns to the Director of Nursing.

Medicines

- The CQUIN for medicines management identified an improvement of the information in discharge summaries. Antibiotic prescribing checked as clinically appropriate in line with microbiology formulary was partially met.
- We observed medicine cupboards and trolleys locked and stored safely. Medication administration record charts were completed correctly. We saw allergy sections completed.
- Each ward had a dedicated pharmacist and a pharmacy technician.
- Pharmacy input was available on-site Monday to Friday from 9am to 5pm, with an effective on-call service out of hours.

Records

- Medical notes were stored in open trolleys, unsecure on the wards and we saw on AMU the open medical notes trolley in the ambulatory care area was down the corridor completely unobserved by staff near the entrance very open to the public.
- We found nursing care plans were stored securely in document files.

Safeguarding

- Thirteen safeguarding referrals had been made for medical care patients at Royal Shrewsbury Hospital, which were now all closed. Staff were fully aware of how to refer a safeguarding issue and had received training.
- Patients who were known to wander wore roam alerts to protect their safety. This meant that staff were alerted to their movement and whereabouts, keeping them mobile yet safe.
- The safeguarding lead nurse for the trust advised them when reporting incidents and was very supportive. They supported nurses when attending adult safeguarding meetings.
- The new adult safeguarding policy and procedure was introduced throughout Shropshire, Telford and Wrekin in April 2013. All agencies within the local adult safeguarding board, including Shrewsbury and Telford Hospital, have adopted the West Midlands multi-agency policy.

Mandatory training

- Data showed that staff attendance at mandatory training was poor. Due to shortages of permanent staff, staff had not been released to attend mandatory training. Attendance levels for mandatory training were noted to be exceptionally low in some areas in medicine, percentage attendance rates ranged from 80% to 5%. The trust acknowledged this and told us it was looking at ways to improve attendance through ward-based learning.
- We were told of instances when staff had attended training but the trainer had not turned up or when the training was cancelled because of low staff attendance.

Medical care (including older people's care)

Management of deteriorating patients

- VitalPAC, a handheld device, was used to record and monitor patient observations. This system highlighted abnormal readings and alerted staff to a deteriorating patient.
- The VitalPAC system used the data input to calculate an early warning score, a measure of risk for each patient. The system used these scores to alert the staff to patients who may be deteriorating, as well as recording when the next set of observations should be taken, according to the patient's individual level of risk.
- We heard examples of occasions when patient safety was at risk of being compromised during busy times. On a weekly basis capacity issues within AMU had led to patients being cared for on trolleys. Staff had raised incident forms regarding this because they felt the trust did not recognise the seriousness of the situation.
- Comfort rounds were completed on each ward to ensure patients' comfort and safety were recorded between one and four hourly. These were audited by the ward manager.
- We saw pressure ulcer prevention and falls risk assessments were completed where risks had been identified.
- Staff told us that when transferring patients from one ward to another they felt that the wards were left understaffed.
- Care pathways were in place to ensure patients' needs were met. We saw that care plans had been signed and updated.

Nursing staffing

- In March 2014 the Safer Nursing Care Tool was used at the trust to review patient acuity, dependency and staffing in all inpatient areas. As a result of this review, changes to the nursing establishment in adult inpatient wards were recommended and actioned in some areas. Medical care ward staffing had increased, but the majority of the time the extra staff had been agency or bank staff.
- The ward managers were supervisory 75% of their time. The ward sister led a team of staff on a daily basis to ensure patients' needs were met. Currently on some wards 50% of the staff was agency or bank staff and this was putting a lot of strain on the permanent staff group, who felt that at times patient observation was not sufficient and care was not always given in a timely way. We were told that the trust policy stated that agency nurses could not administer intravenous medicines as they had not completed the training and competency test required.
- Agency and bank staff completed a full induction and in some areas had been block booked to enhance a consistent team of ward-based staff. Some trained agency staff had completed the trust competency skills assessment, allowing them to complete high-level tasks such as giving intravenous drugs.
- Wards displayed the planned and actual number of staff (registered nurses and care staff staff) on each shift. These posters displayed who was in charge of each shift and when the data was updated. Figures showed that staffing numbers were maintained with a high reliance on bank and agency staff.
- End of the bed and 'bay entrance' handovers were carried out, depending on the sensitivity of the information. We saw that nursing staff used a printed patient handover sheet that was updated before each shift.

Medical staffing

- It had been acknowledged by the trust that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. There were currently three vacancies; this was on the risk register because several attempts to recruit had been unsuccessful. The trust supported an acute unselected take, which means a minimum of eight acute physicians were required to accept any patient coming in to the emergency department.
- The trust told us that they continue all attempts to find sustainable solutions for appropriate cover in emergency medicine. Locum doctors were on the rota to support the team.
- Insufficient junior medical workforce to deliver safe and effective services across two sites had been identified as a concern. In particular the AMUs did not have their own junior workforce and therefore cover doctors were pulled from medical wards, which disrupted ward-based services. Workload and stress levels have resulted in high sickness for juniors; the highest proportion of sickness absence was associated with on-calls and nights.
- The monitoring of recruitment and associated patient risk because of current staffing levels was undertaken through clinical quality review meetings. Acute and

emergency medicine continued to be among the greatest areas of risk. The trust reported that it was continuing work with other organisations and relevant professional bodies to identify sustainable solutions going forward.

- On-call out-of-hours responsibility for the medical team included surgical cover; there was not an out-of-hours surgeon on-site. Out-of-hours cover for weekends and nights was the responsibility of the FY1 (a grade of medical practitioner undertaking the Foundation Programme) and the CT2 (a senior house officer).
- Medical handovers varied from ward to ward, taking place formally and informally throughout the day. Consultant ward rounds took place on all wards five days a week.

Major incident awareness and training

- Staff told us that the trust had a contingency plan if a major incident occurred. They had received basic training on this at induction. The trust worked together with other partners in a local resilience forum because most major incidents would have an impact beyond the trust. They were part of the West Mercia Local Resilience Forum, which helped them to work with other partners across Herefordshire, Shropshire, Telford & Wrekin and Worcestershire to plan for and respond to major incidents.
- Winter pressure arrangements were in place, but a continual annual pressure was apparent. Delayed transfer of some patients to the community had reduced bed capacity.

Are medical care services effective?

Requires improvement

Medical care services required improvement to be effective. Evidence from national audits showed that outcomes for patients could be improved. The trust scored low in the Sentinel Stroke National Audit Programme. There were poor results in rehabilitation goals, speech and language therapy availability and absence of continence plan were some areas which initiated the low score. The trust did not score well in national audits relating to coronary heart disease and management of diabetes.

The lack of seven day service for therapy services was impacting on patient recovery and delaying discharge.

Some ward areas and equipment was out dated and faults were regularly reported and some were placed on the risk register. Staff appraisals had been delayed due to staff shortages and the lack of time to meet with staff formally. Across the medical wards the proportion of staff who had had an appraisal varied from 50% to 90%. Managers had plans in place to complete all appraisals by the end of the year. Multi-disciplinary team meetings were effective, well managed and consistently carried out in all ward areas.

Evidence-based care and treatment

- We saw that policies based on NICE and Royal College guidelines were available for the staff and accessible on the intranet.
- Evidence based care was promoted for the prevention of venous thrombo-embolism (VTE). For example, the use of prophylaxis anticoagulants.
- Care pathways were implemented in accordance with NICE guidance, such as the stroke pathway.
- Specialist treatment and care was provided for people who have experienced stroke or transient ischaemic attack, including facilities for rehabilitation.
- The promotion of the FRASE assessment by the falls prevention practitioner and dementia project lead nurse had shown a reduction of in-patient falls. Improvements in patient safety resulted in 15% reduction in falls.
- Patients were assessed on admission and risk assessments were put in place to reduce the risk of harm such as falls and pressure ulcer development.

Nutrition and hydration

- Patients told us the food was generally edible and presented well.
- Dieticians supported and advised ward staff on patient care for diseases such as diabetes.
- Clinicians took advice from dieticians in developing diagnoses of nutritional problems. They provided individualised dietetic intervention using their expertise in food, nutrient, drug interactions, enteral feeding and counselling skills.
- The red tray system was used to alert staff to support patients requiring assistance with their diet.
- Nutritional risk assessments were in place for some patients. We saw food charts completed that patients confirmed were accurately recorded.
- We saw fluid balance charts in place. We saw that the 'offered' and 'actual' fluid intake was recorded accurately, reflecting a patient's exact fluid intake.

- We saw dieticians observed the VitalPAC scores and monitored patient wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of their responsibilities around the Mental Capacity Act and deprivation of liberty safeguards. They were able to demonstrate a good understanding of the process.
- The mental health team attended the wards on request to support patients to make decisions if needed.
- We observed patients being asked for verbal consent before procedures were carried out.

Patient outcomes

- During 2012/13, 433 myocardial infarction patients (reported as STEMI) were seen by a cardiologist or a member of team and admitted to a cardiac ward, of whom 399 were referred for or had angiography. This meant that appropriate action was being taken in a timely way.
- The trust submitted data to the Sentinel Stroke National Audit Programme, which aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. The Sentinel Stroke National Audit Programme is pioneering a new model of healthcare quality improvement through near real-time data collection, analysis and reporting on the quality and outcomes of stroke care. The trust was assessed as Level E in September 2014. Poor results in rehabilitation goals, speech and language therapy availability and the absence of a continence plan were some areas that led to the low score. An improvement plan for 2014/15 was in place.
- The acute stroke service was based at Telford; the majority of the patients on the stroke ward at RSH were admitted for rehabilitation.
- The trust submitted data to the Myocardial Ischaemia National Audit Project, which was established in 1999 in response to the national service framework for coronary heart disease. It examined the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales. Myocardial Ischaemia National Audit Project 2012/13 showed the trust to be worse than the England average for three measures at both hospital sites.
- The trust submitted data to the National Diabetes Inpatient Audit, which audits diabetic inpatient care in England and Wales. In the 2013 survey, overall satisfaction scored 69.6%, meal choice scored 63.6% and staff knowledge scored 82.5%.
- 11 of 21 National Diabetes Inpatient Audit measures were better than the England average and 10 measures worse than average, including medication and management errors, poor staff knowledge and delayed foot risk assessments.
- Standardised relative risk of readmission was worse than the England average for gastroenterology. Clinicians felt that the only possible recurring reason for readmission to gastrology related to patients requiring paracentesis, which would be a planned admission. Further work to understand the issues was planned.
- The readmission rate to medical oncology was higher than the national average because it included elective chemotherapy delivered on the ward. Work was ongoing within the service to transfer what had historically been in-patient delivered chemotherapy regimes into the day care facilities.

Competent staff

- Staff told us they had received informal supervision in the form of team meetings and occasional one to ones with the ward manager. Staff told us that the senior staff were supportive and available to discuss any concerns. They felt listened to and valued.
- Dementia care awareness training had been introduced, but this had not been embedded within the ward areas.
- Staff told us they had attended training to improve their communication skills and we saw evidence of good communication between staff and patients.
- Staff told us they were actively encouraged to undertake specialist courses, but staffing levels had limited the access to these.
- A revalidation management system was implemented as a requirement for all appraisals of medics in the trust in 2013. This raised a person's awareness to their behaviour and attitudes. The system provided one location for the storage of appraisal information, enabling the medical director/responsible officer more effective management of appraisals, portfolios and promotes 360-degree feedback from colleagues and patients. To improve assurances the NHS recruitment website for doctors had now been developed to include questions on revalidation and appraisal.

Medical care (including older people's care)

- Appraisals for the ward staff ranged from 47% to 100%. Therapy services staff appraisals ranged from 50% to 66%. Staff appraisals had been delayed because of staff shortages and the lack of time to meet with staff formally.
- Some managers had received 360-degree appraisals, which allowed them to reflect on their own practice and respond positively.

Multidisciplinary working

- Local collaborative working had led to the development of a heart failure service for the people of Shropshire.
- The Shropshire heart failure service was underpinned by multi-professional working across the primary/ secondary care interface. There were three heart failure specialist nurses located at the hospital. The aim of the new service was to improve outcomes in chronic heart failure by affecting quality of life, reducing hospital length of stay and hospital re-admissions and, when necessary, improving the end of life experience for patients and carers. The service provided access to appropriate investigations to confirm or refute the diagnosis of heart failure, an advisory role to healthcare professionals, patients/carer education and an advice line.
- Multidisciplinary team working was effective. We saw examples of rehabilitation services working together to support safe discharge of patients and support for carers. We also saw external multidisciplinary team working, with cross-site discussions taking place to ensure the patients were receiving the optimum care from the trust.
- The inpatient diabetes specialist nursing team focused on patient support and education. They supported staff by sharing their knowledge and improving care standards. The diabetes specialist nurse liaised with other healthcare professionals when required. The nurses regularly visited ward areas and departments to provide specialist advice for both staff and patients. They were responsible for supporting ward staff and departments in delivering a high standard of diabetes care and provided teaching sessions. They also supported the outpatient clinics for diabetes reviews, type 1 diabetes in pregnancy and joint renal and diabetes clinics.
- Patient handover from department to ward was by telephone and handover sheet; plans had been discussed that this should be nurse to nurse handover, which the staff welcomed.

Seven-day services

- We were told that to improve patient outcomes the consolidation of stroke services will continue during 2014/15, aiming for a seven-day service.
- Currently seven day ward rounds were not being carried out.
- Occupational therapy or physiotherapy services were not available at weekends or bank holidays. Because rehabilitation services were unavailable during weekends, the physiotherapists and occupational therapists had trialled Saturday working on a voluntary basis, to ascertain its value. Supporting patients' recovery had been a huge success in promoting earlier, safe discharge, but this had not been promoted by the trust.
- At present the trust is unable to provide a full seven-day stroke service and recruitment to a fourth consultant post had been identified, with the plan being to expand the team by the end of 2014.
- To support patients' safe care, consultant presence out-of-hours was through the on-call rota. Haematology on-call was based on-site. Weekend out-of-hours imaging and pharmacy was available through an on-call system. The outreach team was available within the wards for support of a deteriorating patient and the 'hospital at night team' was also available. Pharmacists were in the hospital on Saturday mornings to dispense and support weekend discharges.

Are medical care services caring?

Good

Medical care services were caring. Patients and relatives we spoke with were all satisfied with the care they received. We heard no negative feedback. Friends and Family Test response results varied across the wards. Some wards had higher response rates than others, we saw ward managers were using their initiative to ensure all staff asked patients for their feedback. Patients and relatives told us staff were kind and caring. Patients were informed about their care and knew what was happening to them.

Medical care (including older people's care)

Compassionate care

- Friends and Family Test data showed that the medical wards scored positively for the most recent results for July 2014; however, ward 32E had scored below the England average in the preceding months.
- CQC inpatient survey results scored average for all areas, but below average in patient views being sought and the availability of how to make complaints.
- Clinical commissioning group cancer patient satisfaction results showed that although local patients seemed broadly satisfied, they did not feel that they had been offered written assessments or care plans, scoring just 16%. This appears to be a nationwide issue: nationally, scores ranged from 7% to 35%.
- We observed compassionate care and attention being delivered. Patients told us they had been well cared for.
- We observed staff protecting patients' privacy and dignity, shutting curtains around the bed area securely and lowering their voice to discuss personal information.
- Staff were observed to be kind and caring when supporting people's mobility and offering support during meal times.
- We saw staff introduce themselves to patients and relatives.

Patient understanding and involvement

- All the patients we spoke with told us they were aware of what was happening to them; they told us they felt involved with their care.
- Patients told us they felt safe and their fears were alleviated by the nursing and medical staff.
- Two people told us they felt informed about their relatives care and that all the staff had been very supportive. They told us their relative had been given undivided attention and staff appeared to be very kind and caring.

Emotional support

- Clinical nurse specialists offered emotional support and advice for patients and staff.
- Chaplains work as a team of whole-time and part-time chaplains with the support of volunteers 24 hours a day, seven days a week. They represented different denominations and had contact with all the major faith communities.
- The experienced bereavement care team at the trust provided a caring and compassionate service, offering support and reassurance, information and guidance.
- The trust offered a range of options for emotional and psychological help in their programme of supportive and psychological therapies.
- We observed registered nurses, healthcare workers, therapists and student nurses assisting patients, demonstrating respect and kindness, maintaining their dignity at all times.
- We observed reassurance and advice being given to patients and we saw that patients had their call bell within reach.
- Patients told us that they thought the call bells were responded to within good time and they had not had to wait an unreasonable amount of time for attention.

Are medical care services responsive?

Requires improvement

We judged that medical services required improvement to be responsive. There was evidence that the short stay unit was not being used to its maximum potential. The average length of stay was five days yet one patient had been waiting 15 days for transfer to a gastroenterology bed on the site. The unit had developed admission criteria with an operational policy to address the correct use of the beds. The flow of patients through the hospital was disrupted due to high numbers of medical patients being admitted and delays in discharge arrangements being made. This led to medical patients being cared for on non-medical wards and increasing the dependency for nursing care on those wards.

The trust planned to introduce a more person centred approach to care and services for patients living with dementia that included an integrated patient pathway using best practice working across primary, community and secondary care. They had trained dementia champions in some areas and improved signage and labelling on key wards. This process had been delayed due to staff shortages. Patient complaints were listened to and responded to. PALs leaflet and how to complain information was displayed throughout the hospital.

Service planning and delivery to meet the needs of local people

- The Commissioning for Quality and Innovation (CQUIN) payment framework sets targets for the trust to meet. Targets for dementia care had been met, including

ensuring that at least 90% of patients aged over 75 and who were admitted were assessed and referred on to the specialist services. The trust ensured that there was sufficient clinical leadership and appropriate training undertaken to adequately support carers of people with dementia.

Access and flow

- From data supplied by the trust, there were 1,055 medical outliers from May 2013 to April 2014. The cardiology speciality accounted for 30% of these.
- The amount of medical inpatients exceeded the medical beds available which led to patients being cared for on other wards. This impacted on the ward acuity and staff told us that at times care delivery was delayed due to the pressure of the workload.
- Medical outliers on other speciality wards had impacted on ward managers and senior staffs' clinical time; an increase in consultant ward rounds had meant less time to manage their own patients.
- There was evidence that the short stay unit was not being used to its maximum potential. The average length of stay was five days yet one patient had been waiting 15 days for transfer to a gastroenterology bed on the site. The unit had developed admission criteria with an operational policy to address the correct use of the beds.
- During 2013/14 the trust focused on improvements to support patients when ready for discharge. A new discharge procedure and a discharge information leaflet for patients were introduced. Patient choice letters were issued to all patients to explain the admission to discharge process.
- A discharge hub was established that provided a centralised control centre to aid communication between the trust and its external partners. This has since been closed and patients are discharged from the wards. Discharge coordinators supported the wards and attended bed capacity meetings.
- Staff and patients told us that discharge arrangements were discussed at the earliest opportunity to ensure patients were discharged home safely and adaptations could be arranged if necessary. We saw occasions when discharge arrangements had not been planned in advance which led to delays in to the community.
- Some delays in discharge were noted by staff to be a result of social care issues and arranging care and support in the patient's own home. Lack of support for stroke patients at weekends also delayed discharge because no therapy services were available.
- Referral to treatment (RTT) was above standard and in line with the national average. RTT was meeting all of the five required standards. RTT for general medicine was 100%. The trust has developed a RTT patient information leaflet explaining the 18-week patient availability of treatment.

Meeting people's individual needs

- Single-sex accommodation was provided on all the medical wards.
- The trust had developed guidelines following investigations and reports, such as Healthcare for All (2008) and Six Lives (2009). These had highlighted the additional need for 'reasonable adjustment' to service delivery when patients with a learning disability were admitted to a general hospital. The objective that the patient will be nursed in a safe environment was supported by a reference guide to assist in the planning of care for patients with a learning disability who were admitted to or who attended the trust.
- A learning disabilities nurse specialist supported patients with a learning disability diagnosis.
- The trust was addressing the quality of care provided to patients living with dementia in some areas. They planned to introduce a more person-centred that included an integrated patient pathway using best practice working across primary, community and secondary care. Dementia champions had been trained in some areas and improved signage and labelling on key wards was seen. This process had been delayed because of staff shortages.
- The trust had listened to carers groups and implemented a carer's passport scheme that enabled a designated carer or family member carer to support a patient's stay in hospital outside of normal visiting hours. The main beneficiaries of the scheme were people caring for patients living with dementia; planned to and people who have a significant caring role for the patient in the community. The scheme encouraged staff to value and support each person's carers and to include them as active members of the care team and to support their visits during the day. We saw evidence of this on the wards.

- The Butterfly Scheme had been introduced to support patients living with dementia. However, there was no equipment available such as adapted cutlery, crockery or environment enhancements to support the scheme on the stroke unit or wards.
- A revised tool had been introduced for the identification and screening of patients with dementia. A dementia care bundle had been made available and was fully embedded in the elderly care ward.
- The trust had implemented a scheme to identify carers for those patients with dementia and signpost them to help and support. They have worked with the patient and carers hospital liaison worker to support families and carers. The inclusion of carers and relatives had improved this in the stroke unit.
- Staff told us they worked in an environment in which employees, patients and visitors are treated with consideration, dignity and respect, free from harassment and intimidation.
- The trust arranged when necessary for an interpreter or translator to assist patient consultation either face to face or by telephone. Interpretation services were available in both the form of a language line (a telephone translation service) and face-to-face interpreters.
- We saw a many advice/information leaflets were available for patients and relatives to read about self-help, medical conditions and access to services.

Learning from complaints and concerns

- The annual complaints and Patient Advice and Liaison Service report for 2013/14 stated that 70 complaints were received for medicine care services across the trust.
- Medical concerns were primarily relating to diagnosis, treatment and complications that occurred as a result of treatment. Of those complaints relating to staff attitude, 37 of these related to nursing and 28 to medical staff. During the year the trust launched its values, setting out the behaviours expected of every member of staff. Further work was on-going to embed these values throughout the organisation.
- The complaints team usually met with heads of nursing and matrons each month to highlight themes and further action required. During the last quarter, the complaints team had met with the clinical governance lead and senior managers from each specialty every two weeks to highlight new complaints and agree actions and learning. Each specialty was now seeing a reduction in the number of complaints it had received.
- The matron for medicine reviewed each complaint and the issues were discussed within ward meetings.
- We saw 'Don't take your troubles home with you' stickers on lockers to support patients to raise concerns before being discharged.
- The Patient Advice and Liaison Service was available to give support and advice and we saw leaflets on the wards to support patients to make complaints and raise concerns. Patients we spoke with were aware of how to make a complaint.

Are medical care services well-led?

Good

We spoke with staff who were aware of the trust's vision and values. Staff told us about the new open culture. They felt they were well managed at ward level, but there was some disconnect between them and the senior executive team. It was acknowledged that staff shortages had impeded some initiatives. For example, the dementia care initiative and delayed discharges into the community had resulted in poorer outcomes for some patients. Medical staff shortfall had also caused stress and anxiety for the workforce. Ward-level leadership was found to be effective and well managed. Staff had received recognition and rewards from the trust.

Vision and strategy for this service

- Staff told us that the trust's vision was to ensure that the interests of the patients were at the heart of everything they do, providing the best possible care for them. The trust's values represented a commitment that the decisions they make will be in the best interests of the people they serve and the people they employ.
- Staff were familiar with the trust's values, which were: proud to care, make it happen, we value respect and together we achieve. These values were now incorporated within the induction and appraisal process and staff told us they welcomed them.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Monthly ward to board quality reviews were completed and monitored. These included monitoring comfort round checks, speaking with the patients, ward cleanliness and patient knowledge and understanding of their medication.
- Nurses described difficulty accessing the local governance meetings with medical colleagues because of staff shortages, which could compromise multidisciplinary learning from incidents and complaints.
- There were several items on the medical risk register including: lack of piped oxygen and suction in the renal unit along with water supply issues, the need to replace outdated renal dialysis station, medical workforce shortfall including care of the elderly, neurology & dermatology, and significant trained nurse vacancies on medical wards were identified.
- It was evident that the management team were aware of the key challenges for the service and were working to resolve them.

Leadership of service

- Ward-level leadership was found to be robust and effective.
- Rewards and recognition were in place and staff told us how they had achieved the Chairman's Award. "Chocolate Box Moments" were awarded to ward staff with zero pressure ulcers reported.
- On many occasions nurses told us that they felt able to raise concerns with senior management and were listened to.
- Staff told us their director of nursing was approachable and very supportive.

Culture within the service

- A new open culture was described by staff, team work was improving and they felt able to speak with the executive team when they visited the wards.
- All the staff we spoke with felt supported by the matrons and ward manager/sisters.
- Although disconnect was described between ward staff and executives, there was evidence of high visibility of the director of nursing among ward managers spoken to and they valued their support.

Public and staff engagement

- The trust had introduced a quarterly newsletter for public trust members, 'A Healthier Future'. The newsletter was sent to all trust members by post or email, and could also be downloaded from their website.
- The role of the volunteer was a vital role within the hospital, working in a variety of departments alongside staff. There were over 400 trust volunteers working across both hospital sites, involved in a wide range of areas including chaplaincy, ward helpers, dementia activities and mealtime buddies.
- Patient representatives were visible throughout the hospital.
- Staff were being encouraged to promote the Friends and Family Test.
- The trust newsletter updated staff on current issues. Ward meetings were held to discuss local issues with their own staff.
- An intranet site was available for all staff which held the trust policies and procedures.

Innovation, improvement and sustainability

- The trust plan to focus on ensuring improvements in dementia care, reducing harm to patients and the experience of patients, relatives and carers over the next 12 months.
- The trust was awarded third prize for Innovation in Dementia Care by the Royal College of Nursing in May 2014. The award was presented to the trust during Dementia Awareness week, also in this week, the trust introduced the national Butterfly Scheme, which allowed people with memory impairment to receive a specific form of personalised care during their stay in hospital.

Surgery

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

Information about the service

Royal Shrewsbury Hospital provided adult inpatient and day surgery services for specialisms including trauma orthopaedic, vascular, urology, colorectal and ophthalmology. The hospital had 22,167 admissions in 2013/14, with almost half being emergency admissions. The hospital has consistently struggled to meet the 18-week referral to treatment time (RTT).

We inspected the preoperative admission clinic, theatres and recovery, three wards and the day surgery unit. We spoke with staff, patients and their relatives and carers, and we observed care and reviewed records as part of this inspection.

Summary of findings

Patients were not adequately protected from avoidable harm as medical records were not stored correctly. We were concerned that patients received care on a ward with no heating and where the emergency alarms were deficient. The trust took immediate action to rectify these findings. Services were not always effective because of out of date care pathways, lack of competency assessments and lack of physiotherapy services for patients with fractured hips.

We saw many instances of good care, but we also saw a number of poor care practices and a senior member of staff told us they did not always have time to explain things to patients. Surgical services were not responsive; they struggled to meet treatment times, some patients were kept in recovery for long periods while waiting for a bed, and not all patients could use the bathing facilities. Not all staff could explain a vision for the service they worked in, they felt under pressure and were not always supported by senior management. Governance arrangements meant that the service was not well led.

Surgery

Are surgery services safe?

Requires improvement

Surgical services required improvement. We found there was an inconsistent approach among staff to incident reporting and there were instances of medical records being left unattended with other patients and relatives. We had significant concerns for the welfare and safety of patients using Ward 31 (day surgery) because the area in use had no heating switched on, emergency call bells did not alert other staff to emergency situations and medical equipment was stored on shelves accessible to the public. We raised this with the trust during the visit and initial plans involved moving patients on this ward. However, at our unannounced visit we found that this ward was still being used, but that the issues with the heating and call bells had been addressed. We were reassured that the issues we raised had been sufficiently addressed.

Mandatory training was in place, with variable rates of completion. Staff were aware of their responsibilities for safeguarding and the Mental Capacity Act. However, there was a high level of vacancies for qualified nursing staff on a number of wards and the staffing of Ward 31 was insufficient. This was compounded by the lack of a real time acuity tool to determine safe staffing levels for patients. The trust reviewed staffing levels using planned acuity and dependency on a quarterly basis using the NICE approved Safer Nursing Care Tool.

Incidents

- There had been 32 serious incidents reported by the trust across both hospital sites in the 12 months before the inspection. Pressure ulcers were the most frequently reported serious incident.
- We spoke with staff who told us that they were aware of the electronic incident reporting system and that they reported incidents. However, four staff we spoke with told us that it took too much time to complete the form and when they were busy they were not always able to do so.
- We saw meeting minutes that showed learning from incidents was fed back to staff but we were concerned that if staff failed to report incidents, then learning could not be demonstrated.
- Governance meetings, including mortality and morbidity meetings, were undertaken within the directorate. Meeting minutes we reviewed confirmed this.

Safety thermometer

- The NHS Safety Thermometer was in use by the surgical directorate.
- We saw that the data indicated good compliance with hand hygiene, VTE assessments and pressure area care and assessment.
- While the thermometer was visible in the majority of wards, we found that it had been removed from the orthopaedic trauma ward (Ward 22) and was not available to patients. We spoke with staff, who were unsure about the reason for this.

Cleanliness, infection control and hygiene

- Data reviewed before the inspection showed that MRSA rates were better than the England average for the trust. C. difficile infections were also better than the England average for the majority of the period.
- The surgical directorate took part in the national surgical site surveillance run by Public Health England. The last available data for 2012/13 showed that infections were better than the England average.
- Theatres and ward areas were clean and we saw that cleanliness of the clinical areas was regularly audited and found to achieve 95% or higher.
- There was sufficient personal protective equipment available and we saw staff using the equipment appropriately.
- Staff worked in accordance with trust policy and were ‘bare below the elbows’ and maintained correct hand hygiene.
- On one occasion we saw a surgical doctor on the ward reviewing patients wearing theatre ‘scrubs’ and footwear. Theatre wear is usually restricted to the operating theatre to reduce the risk of infection being carried in from the ward areas>

Environment and equipment

- We found that some of the clinical areas such as Ward 26 had corridors cluttered with trolleys, dressing trolleys and a bed. We were told there was insufficient storage space. This meant that the risks of trip hazards for patients and staff was increased.

Surgery

- Staff told us that they had sufficient equipment such as infusion pumps and pressure-relieving mattresses and they did not have trouble accessing these devices.
- Emergency equipment on the wards was checked daily to ensure it was complete and ready for use.
- We visited Ward 31, which was being used as an eight-trolley day surgery unit and had been opened the week before our inspection. We had a number of concerns regarding the environment on this unit.
- The heating for this clinical area had not been switched on, even though it was October. Staff told us they had requested five times for the heating to be turned on. We saw two Friends and Family Test comments cards from patients who had been treated on the day of our inspection. Both identified the ward area as being cold. Patients who have recently had a general or local anaesthetic should be cared for in a warm, comfortable environment because there are risks associated with anaesthetics. We raised our concerns at the time of the inspection and the trust took action. We revisited the ward during our unannounced inspection to confirm this had been rectified.
- We asked about emergency support for the ward because it was some distance (approximately 150 metres) down public corridors to the main day surgery unit. We tried the emergency alarm and found that it was only clearly audible on Ward 31 and could not be heard on the adjoining medical assessment unit. We were concerned that in the event of an emergency, staff on the unit were not able to summon assistance quickly. We raised our concerns at the time of the inspection and the trust took action. We revisited the ward during our unannounced inspection to confirm this had been rectified.
- There was a lack of storage on Ward 31. This meant that some clinical equipment was stored on open shelves in the public area of the ward. This equipment included needles and syringes and blood collection bottles. This meant that the general public could access this equipment and injure themselves.

Medicines

- We found that medicines were stored securely and correctly and administered in a timely way.
- Medicines that required refrigeration were kept in a locked fridge. Temperatures were checked daily and we found them to be within acceptable limits.
- Staff told us that pharmacy were able to supply medicines quickly so that patients received the right medication at the right time.
- We were told that there could be some delay on occasions for medicines for patients to take home when discharged, but most patients received their medication in a timely manner.

Records

- Records were a mixture of paper records and an electronic package called VitalPAC that recorded patients' observations and indicated when assessments were required.
- We saw there was some duplication of records, whereby observations and assessments completed electronically were then transcribed onto paper records.
- Medical and nursing staff kept their records separately.
- We saw that risk assessments for pressure areas were appropriately completed and action taken in response to the assessment.
- We were concerned to find on the day surgery unit a 'lounge' room for patients awaiting eye treatment. Staff told us the room was being used in this way because of the pressure on the day surgery unit beds. We saw that there were a number of patients and relatives in the room and that patients' medical records on a trolley in the room were easily accessible. During our observation there was no staff in attendance.
- We saw that the World Health Organisation (WHO) 5 step to safer surgery checklist was completed in theatres and that it appeared well embedded in practice. The checklist was regularly audited, with over 1,400 patients audited showing 100% compliance.

Safeguarding

- Staff had received safeguarding training for adults in line with mandatory training.
- Six staff we spoke with were aware how to raise a safeguarding concern within the hospital and what constituted a safeguarding. They told us they were well supported by the hospital safeguarding team.

Mandatory training

- Staff told us they were up to date with mandatory training and that it was completed as face to face and electronic learning.
- Training included basic life support, moving and handling, and infection control.

- Some mandatory training was tailored to specific areas such as theatres.
- Data provided showed that not all ward areas were up to date with mandatory training, with some wards achieving 80% compliance with mandatory training, while others such as trauma had only 67% compliance.

Management of deteriorating patients

- The surgical wards used the 'early warning system' to alert staff to patients who were becoming increasingly unwell. This score was calculated by VitalPAC from the observations recorded.
- Staff told us they were well supported by outreach staff from the critical care unit. Staff on the intermediate care area of Ward 26 told us that outreach staff visited them daily.
- We were told that medical staff responded promptly when requested by nursing staff to review patients.

Nursing staffing

- Data we reviewed before the inspection indicated that the trust had a higher than the England average use of agency and bank staff.
- We found that some wards had high vacancy rates for permanent nursing staff. Ward 22 had vacancies for six full-time nurses and had a further three nurses who would not be available to work for some time. This was a significant proportion of staff, because the ward had 24 beds.
- We reviewed rotas and found that safe staffing levels were maintained most of the time, but with a heavy reliance on bank and agency staff.
- Staff on all the wards we visited told us that they regularly cared for patients from specialties other than their own and who may require different levels of care. We asked if an acuity tool was used to determine the needs of patients and the correct level of staffing, but we were told that although point of care audits were completed, no acuity tool was used to determine staffing levels or rosters.
- We saw that planned and actual staffing levels were displayed in clinical areas.
- Senior staff told us that whenever possible they used agency staff who were used to working on the ward and at the hospital. Staff told us that, due to time pressures, some agency staff had a limited induction to the area they would be working in.
- On Ward 31 we found there to be a qualified nurse and a healthcare assistant for eight patients on trolleys. We were concerned that in the event of an emergency, and because they were some distance from their main department, there were insufficient staff to safely care for the eight patients. We raised our concerns the same day and have been reassured that staffing has been increased on the ward.

Medical staffing

- Data we reviewed before the inspection showed that while the trust had a higher than England average of junior and middle career grade doctors, it had less than the England average number of senior doctors (registrar and consultant groups).
- There were clear on-call arrangements and staff told us that they were able to get patients reviewed and felt supported out of hours.

Major incident awareness and training

- We saw that there was a major incident plan in place for the trust and for the surgical service.
- There were business continuity plans in place for surgical services that outlined the response to a significant problem and the prioritisation of patients and care.

Are surgery services effective?

Requires improvement

Surgical services effectiveness requires improvement. Some important care pathways were outdated and some patient outcomes measured by audit were worse than the England average. We were concerned as to the lack of competency frameworks for staff caring for patients from a number of different specialties. Physiotherapists did not always review new trauma patients at a weekend, but instead focused on those ready for discharge.

We saw that patients received pain relief in a timely way and through different methods of administration. Documentation relating to nutrition was not always properly completed. We saw good examples of Deprivation of Liberty Safeguards being undertaken and effective multidisciplinary working.

Evidence-based care and treatment

- There were some surgical pathways in place, but they were not always current.

Surgery

- We saw that the fractured neck of femur pathway was dated 2010. NICE guidance for fractured neck of femur was published in 2011 with a short update in 2014. This meant we could not be sure that the pathway reflected current NICE guidance or best practice. Locally, medical and nursing staff had recognised this and were beginning to work towards a replacement pathway.
- We were made aware that only the surgical doctors wrote in the care pathway and that other staff continued to use their own records. We were concerned that this may hinder continuity of care and does not reflect best practice.
- The hospital had started the national emergency laparotomy audit, and the first results are due in 2015.
- We saw that elective and emergency returns to theatre were monitored and actions identified following analysis of the data.
- We saw that staff adhered to local policies in relation to the management and observation of patients before, during and after surgery.
- These conformed to NICE guidance CG50 – Acutely ill patients in hospital.
- There were a number of local audits that were regularly presented to the surgical service governance committee, including the use of prosthesis in colorectal surgery.
- We saw that VTE assessments were completed for patients preoperatively, in line with national guidance.

Pain relief

- For scheduled patients, the pain relief regime was considered initially at the preoperative assessment clinic, which allowed staff to plan effective pain relief for patients.
- We saw that type of procedure, operation duration, patient risk factors and patient choice all influenced the pain relief plan.
- Postoperative pain for people requiring emergency and scheduled surgery was controlled by a variety of methods, including oral pain relief as well as patient-controlled analgesia and epidural. We saw staff undertaking pain assessments for patients who had undergone emergency surgery.
- We spoke with four patients on the wards, who told us that their pain had been well controlled after surgery.

Nutrition and hydration

- Patients who were unable to eat or drink received support in the way of intravenous fluids.

Patients requiring longer term support received total parenteral nutrition, a type of 'feeding' by

- supplying a liquid intravenously.
- We observed care on one of the wards. We saw that two patients refused their lunchtime meal and during our observation were not encouraged to try their meal or offered an alternative. We checked two nutrition charts and found they were not completed fully. This meant staff could not be sure how much patients had eaten and reliably assess their level of need.
- Patients who were assessed as at risk of malnutrition were referred to the dietician.

Patient outcomes

- Data reviewed before the inspection showed that the hospital performed worse than the England average for nine measures in the hip fracture audit, including time taken to surgery.
- The hospital was taking steps to improve this, including 12 months ago the hiring of an ortho-geriatrician and a trauma nurse practitioner a few months before. We received some recent data that showed performance was improving against time to theatre, but that it was still worse than the England average.
- We reviewed information related to the national bowel cancer audit. This showed that the trust was performing better than the England average for diagnosis rate of bowel cancer, number of patients discussed at the multidisciplinary team meeting and CT scan reporting time.
- However, the trust performed worse than the England average for data completeness of records and those patients seen by a clinical nurse specialist.
- Data reviewed showed that readmission rates for elective patients at the hospital were better than the England average.
- Readmission rates for patients for emergency surgery showed that while the hospital overall was in line with the England average, it was worse for general surgery and significantly worse for colorectal surgery.
- Data reviewed for Patient Reported Outcome Measures showed that the majority of patients reported improvement following surgical intervention and was in line with or better than the England average for hernia repair and hip and knee replacement, but was worse than the England average for varicose vein surgery.
- Patients' length of stay following surgery was in line with the England average.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the Mental Capacity Act was adhered to. We saw examples of MCA assessments being undertaken and best interests decisions being taken in conjunction with the relevant professionals and patient representatives.
- We saw that on one ward two patients were subject to Deprivation of Liberty Safeguards. The correct process had been applied and the application for the deprivation of liberty was made to the appropriate authority.
- Staff told us they had received training in the Mental Capacity Act and demonstrated a good knowledge of its implications for their clinical area and practice.

Competent staff

- Some staff we spoke with told us they had received appraisals in the year. We saw that where staff had not had appraisals, some had a date booked for them to be completed. Data provided showed that only 58% of staff had had appraisals on the day surgery unit.
- Consultants we spoke with individually and as part of focus groups told us that they received appraisals, which was required as part of their professional revalidation.
- Nursing staff told us they undertook competency programmes for skills such as medicines management.
- Some wards had a mixture of specialisms such as gastroenterology and colorectal surgery and another ward had urology, vascular surgery and an intermediate care area for patients requiring a slightly higher level of need. We asked if there were competency frameworks in place so that staff had the necessary skills to care for patients of differing needs, but we were told that there were no structured competency frameworks in place.

Multidisciplinary working

- We saw that the multidisciplinary team worked effectively at ward and surgical division level. Staff reported a good working relationship with colleagues of other disciplines.
- Patients were routinely referred to members of the multidisciplinary team for review and specialist input, such as from dieticians and speech and language therapists.
- Cancer patients were routinely discussed at multidisciplinary team meetings to determine the best course of treatment and care for them.
- Staff on a number of wards reported that it was not always easy to have medical outlier patients reviewed by the medical team on a surgical ward.

Seven-day services

- Out-of-hours services were available, including pharmacy and radiology.
- There were clear on-call arrangements for doctors and surgeons overnight and at weekends.
- Orthopaedic trauma patients were reviewed daily on the ward.
- We were concerned to find in orthopaedic trauma that there was no seven-day physiotherapy service because they did not cover weekends for all patients – only patients ready for discharge and chest patients were seen. This meant patients who had surgery for a fractured hip on a Friday may not get specialist physiotherapy until the following Monday. Early mobilisation is an important indicator of patient outcome and reduces the risk of complications.

Access to information

- We saw from ward rounds being undertaken that medical, nursing and allied health professionals had the information they required, such as records and test results, to allow them to effectively care for patients.
- The majority of staff we spoke with told us that access to information was not always possible when there were technical problems with VitalPAC (electronic records). During our inspection the system also failed and staff used a paper system as back-up

Are surgery services caring?

Requires improvement 

We judged that caring required improvement to ensure that all patients were treated with dignity and respect. On Wards 22 and 26 we observed a number of episodes where nursing staff talked about patients in front of others and ignored patients who were crying out. At times we saw little interaction with patients when carrying out personal care tasks. However, we also met with dedicated staff who cared for their patients in a dignified way and saw good staff interactions. Staff told us that they did not always have the time to talk to patients about their diagnosis or future treatment plans.

Surgery

Compassionate care

- Data we reviewed before the inspection and data we saw at the hospital showed that the surgical wards at the hospital scored positively on the Friends and Family Test for the most recent month, July 2014, but several wards including Ward 26, Ward 22 and Ward 25 had scored below the England average in the preceding months.
- Patients told us that most nurses and staff were kind and compassionate.
- We saw a number of good staff interactions with patients. Staff used humour to build rapport with patients and had a good understanding of individual patients' needs.
- In theatres we saw that the privacy of patients was protected and that people were moved in a way to protect their dignity.
- Intentional 'rounding' was in place, and we saw patients regularly checked on to ensure they were comfortable.
- We saw a number of poor care practices. In a bay on one of the wards a nurse and healthcare assistant were talking loudly between themselves. On Ward 22, one said "they don't want this patient to be catheterised", pointing at an elderly patient, and then "Has she wee'd?" This was said loudly in front of other patients. It showed a lack of respect and undermined the patient's dignity.
- On the same ward a patient was crying out. We saw a member of staff stand next to the patient completing paperwork, but they did not engage with the patient or attempt to reassure them.
- On Ward 26 a patient was calling out from a side room. We saw a member of staff go into the side room, reposition the patient in the bed and then leave the room, but did not introduce themselves or explain what they were going to do.

Patient understanding and involvement

- We saw that patients were given adequate time and information to make decisions. We spoke with two patients on the wards who had their diagnosis explained to them. They both told us that they had their questions answered and one said that the consultant had come back to see them to answer further questions.
- However, staff we spoke with told us that they did not always have the time to spend with patients. One senior member of staff said, "Because the ward is so busy we can't always explain everything to patients such as their diagnosis and their treatment."
- Patients we spoke with told us that staff explained their care and treatment to them on most occasions before any care or intervention took place.
- Staff we spoke with told us that they were sometimes concerned about the continuity of care offered to patients because of the use of agency and bank staff

Emotional support

- In the pre-assessment unit, patients were met by a member of the nursing team and directed to the appropriate room for their appointment. Patients told us this was reassuring and welcoming. We saw that patients were given adequate time to answer questions and to ask if they were unsure about their forthcoming operation or procedure.
- Staff told us that there were counselling facilities available in the community, but they were unsure if they were available within the hospital.
- Clinical nurse specialists saw patients on the wards and in preoperative assessment. They were able to offer advice and guidance to patients. One patient told us that they had found it very important to discuss their operation with the stoma nurse and they felt reassured and less frightened as a result.

Are surgery services responsive?

Inadequate

We found that surgical services were not always responsive to the needs of patients. Latest available data from August 2014 showed that the hospital continued to struggle to meet its referral to treatment times for some specialties. Having been admitted, patients were sometimes cared for in recovery for extended periods because no beds were available. The high number of inpatients on the day surgery unit had affected patient flow and led to additional trolleys on Ward 31.

We saw that patients who may be on wards for some time may not be able to have a bath because the facilities were

not adequate. We saw good examples of discharge planning and learning from complaints and the vast majority of patients had their operation rebooked in 28 days if their original operation was cancelled.

Service planning and delivery to meet the needs of local people

- There was an effective pre-assessment department that supported patients in preparation for their operation. There was good flexibility in pre-assessment in that patients could attend the preoperative clinic in Shrewsbury or Telford, depending on what suited them best.

Access and flow

- Information we reviewed before the inspection showed that bed occupancy for the trust in the last quarter with available data was at 90%. This was higher than the England average.
- The number of patients who had surgery cancelled and were not re-booked for surgery within 28 days was better than the England average.
- Data for referral to treatment times was below the national average for the period March 2013 to May 2014. We reviewed the referral to treatment times for August 2014. This showed that the trust was failing to meet the 90% treatment target for orthopaedics (66%), ophthalmology (80%) and oral surgery (65%). They were meeting targets for general surgery (94%) and urology (95%).
- We were aware that the trust reported they had met all referral to treatment times for September 2014, but this data had been not ratified at the time of our inspection.
- Fifty-nine per cent of patients with a fractured hip were operated on within 48 hours at Shrewsbury, according to the most recent available data, which was below the England average (83%).
- We were told that the absence of a dedicated trauma (fracture) theatre list at the weekends had an impact on the time taken for patients with fractured hips to be operated on.
- The number of operations cancelled was in line with the England average.
- We spoke with staff who told us that cancellations in day surgery were common because of the number of inpatients being cared for on the day surgery unit. The week before our inspection the day surgery unit had increased its inpatient beds to 20. We saw that a number of patients would have their admission cancelled because of a shortage of day surgery beds. We were concerned to be told that on occasions the day surgery unit was asked to accept patients directly from the emergency department.
- We were given information that showed patients sometimes had to wait for extended periods in recovery after surgery because there were no ward beds available for them.
- Incident forms we reviewed showed numerous occasions when patients were held in recovery waiting for a bed. Some of these delays were more than 5 hours.
- We observed good practice with regards to the discharge of a complex patient. A full summary was given to community nursing and rehabilitation services, and this was followed up by a call. The community services were invited to a planned discharge meeting to discuss the patient's individual needs.

Meeting people's individual needs

- We asked which translation services were available. Three staff told us that translation services were available; however, three other staff were unsure how to request translation services.
- On Ward 26, we were told there were a number of long-stay patients with mobility problems. We viewed the bathroom facilities and found them clean but old and outdated. There was no hoist available and staff told us that the previous equipment had not been fit for purpose and so had been removed. This meant that patients with mobility problems were not able to have a bath.
- Bariatric equipment was readily available; staff told us there was no delay in getting this equipment if it was needed.
- Inpatients in day surgery were regularly encouraged to wash and dress early and sit in a chair to allow a day case patient to use the bed. Staff told us that they felt they hurried patients in this way.
- The preoperative assessment clinic undertook holistic assessments of patients' needs so that a detailed plan could be made for their care and treatment, tailored to their individual circumstances.
- Information was available to patients in written form, such as leaflets, and other information was sent to them before their operation.
- Because of the configuration of day surgery, some patients were taken to theatre through a large public atrium area, which affected their privacy and dignity.

Surgery

Learning from complaints and concerns

- We saw that ward areas kept a log of complaints received.
- We examined two complaints and the steps taken to address the concerns. This had involved staff meeting the patients and relatives involved to be sure of their concerns. We saw that action plans had been developed to address the concerns and change practice.
- Staff we spoke with told us that they received feedback about complaints and any changes to practice or procedure. Meeting minutes showed this to be the case.

Are surgery services well-led?

Requires improvement

The service was not well led because there was poor governance oversight in service configuration and a number of staff we spoke with felt unsupported by senior management and received inconsistent information. Some staff spoke of a blame culture.

Not all staff were aware of the vision or strategy for the service they were working in. There were governance meetings across the directorate that focused on service improvement and mitigation of risk.

Vision and strategy for this service

- We spoke with a number of senior nursing and medical staff. Some staff could articulate the vision for their ward and service. The ortho-geriatrician had a clear vision for the future of their service and this was well supported by senior ward management.
- However, we spoke with a number of staff who were unsure about the purpose of and future for the services they were providing. This was because of organisational change and lack of or inconsistent information given to them by senior managers.

Governance, risk management and quality measurement

- We saw that a number of governance meetings were held across the surgical services to highlight change to practice and present audit data.
- Attendance at the orthopaedic governance meeting was predominantly by medical staff, though senior nurses from the ward also attended.
- Minutes showed that audit data as well as risks were discussed. We saw that items on the risk register were also discussed at this meeting.
- Orthopaedic governance meetings were held quarterly. The hospital had poor performance against national hip fracture audit data and we could not be sure that quarterly meetings were sufficient to review performance.

Leadership of service

- Staff spoke highly of their ward-level managers and had confidence in their leadership. They felt supported in their work and to take on additional skills. However, they told us that they did not always feel supported by their senior managers.
- Staff told us that they sometimes saw the director of nursing on the wards, but did not think they had seen any other senior management on the wards.
- One ward had a four-bedded intermediate care area. This area cared for patients who required closer monitoring, such as following surgery, and had equipment for monitoring heart rates. We asked ward staff what level the beds were given (they were a 'step down' from ITU/HDU), but they could not tell us. We were concerned that staff were unsure of the services they were providing on their ward.

Culture within the service

- Staff we spoke with were open and honest about the challenges they faced and how they were managing them.
- Some staff were clearly passionate about the care they were providing and positive about the future. However, we spoke with several staff who were clearly upset at the issues they faced and the lack of support and leadership from senior managers. Several spoke of a blame culture at the hospital.
- Some senior staff demonstrated disengagement with senior managers. When discussing failure to report staffing incidents, one told us "I am not sure they [managers] are interested in my staffing levels."

Public and staff engagement

- We saw that response rates for the Friends and Family Test across surgical wards were below the England average. We saw that Ward 25 had scored poorly for

March and May 2014. The Surgical Assessment Unit and Ward 22 had scored below the England average for June 2014, but all wards scored better than the England average for July 2014.

- Not all staff we spoke with felt engaged by senior staff and managers. Staff told us that they were not always involved in making decisions about their services or how they were provided.

Innovation, improvement and sustainability

- We saw that that the hospital was taking action to improve its hip fracture audit data by redesigning the service around an ortho-geriatrician and new nurse practitioner.
- Staff on another ward showed us how they were developing enhanced care pathways for patients and multidisciplinary working.
- The team in the pre-assessment clinic were managing new ways of working that meant patients could be seen at either hospital site for preoperative assessment.

Critical care

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

Information about the service

Royal Shrewsbury Hospital has an intensive care unit (ICU) with a maximum of eight beds and a separate high dependency unit (HDU) with a maximum of six beds. The ICU and HDU provided a mix of level-three and level-two beds. Level three are beds for patients who are critically ill, are ventilated and have other complex care requirement. Level-two patients also are critically ill and have complex care needs, but may not require ventilation. The ICU and HDU admitted 668 patients between August 2013 and August 2014. The coronary care unit provided eight beds and had admitted 1,141 patients between August 2013 and August 2014.

Intensive care consultants provided medical cover for the ICU and HDU from 8am until 5pm Monday to Friday. Over the weekend a consultant, who may be either an anaesthetist or an anaesthetist with additional experience/ qualification in intensive care medicine, was available during the day on-site and during the evening and night on-call from home. A consultant cardiologist provided medical cover on-site six days a week and on the seventh day there was an on-call arrangement from Princess Royal Hospital. Evening medical cover for ICU and HDU was provided by a registrar on-site, with a consultant on-call from home. The coronary care unit also had a registrar on-site during the evening and overnight, and a consultant on-call from home.

We visited the ICU, HDU and the coronary care unit. We talked with 11 patients, ten relatives and 20 staff: nurses, doctors, physiotherapists, domestic staff and managers. We observed care and treatment and looked at five patients' records who were receiving or had recently received care within the critical care wards. Before the inspection we had reviewed performance information about the hospital.

Critical care

Summary of findings

Critical care services were found to require improvement overall. The critical care service staff were caring and compassionate and we judged that this domain was good.

There were not enough suitably skilled and experienced staff on the unit, which represented a significant risk to patients. When we highlighted the staffing shortfalls to the trust they took immediate action to ensure that sufficient and appropriate nursing staff were available to care for patients in ICU and HDU.

Critical care services were obtaining good quality outcomes, and patients received treatment that was based on national guidelines. The general capacity of beds in the hospital was a challenge. Bed capacity had also impacted on critical care services both in the availability of the beds within critical care and also delays in discharging patients to other wards.

The trust had two small critical care units and found it difficult to ensure that sufficient and suitably experienced medical and nursing staff for both units were available. There are plans to review the critical care services that are provided by the trust to ensure that safe and effective care and treatment are provided.

Improvements were required to the leadership of the critical care services, to ensure that the management responded appropriately to staff and that the service provided met national core standards.

Are critical care services safe?

Requires improvement

We found that the safety of critical care services required improvement. When we first visited the hospital there were insufficient experienced nursing and medical staff to manage the intensive care service and unsafe arrangements for coronary care nurses. We highlighted our concerns about staffing arrangements to the trust, who took immediate action to ensure that there sufficient and appropriate staff available.

Staff were able to report incidents, but a lack of feedback from these incidents meant that they were not confident that appropriate actions were being taken. This had resulted in lethargy over reporting concerns such as low or insufficient staffing levels that were highlighted during the inspection. The critical care units had low infection and pressure ulcer rates. There were comprehensive investigations into incidents that had resulted in serious harm, such as infections and pressure ulcers. There were appropriate systems in place to highlight the deteriorating health of a patient.

The environment was visibly clean and hygienic. Arrangements for medicines were generally appropriate.

Incidents

- There had been two serious harm incidents associated with critical care services that were reported to the National Reporting and Learning System. These incidents related to two grade-three pressure ulcers between August 2013 and August 2014.
- We looked at the root cause analysis investigations (RCA) for these incidents. They were comprehensively investigated and were judged to be unavoidable. The RCA investigations identified how learning would be shared and actions that would and are being undertaken to reduce the risk of a similar incidents in the future. We also saw that required actions had been addressed or were in place
- Staff we spoke with said they had reported incidents such as pressure ulcers, falls or general concerns about care. Staff told us that they did not always receive feedback about incidents they had reported and were not confident that required actions would be taken in response to the incident they had reported.

Critical care

Safety thermometer

- We saw that information about the incidence of pressure ulcers, infections and falls was displayed within main ward area of the coronary care unit. However, similar information was not prominently displayed within the ICU or the HDU.
- The hospital safety information, which was updated monthly, showed that the ICU, HDU and coronary care unit were performing as expected for the safety indicators.
- There were low numbers of catheter urinary tract infections and falls. The number of pressure ulcers had recently increased, but overall the numbers were similar to other trusts.
- Risk assessments for patient pressure ulcers and VTE were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- The units had low infection rates in the previous 12 months.
- Patients were cared for in a clean environment. There was an identified cleaning programme, which had been completed correctly in the ICU, the HDU and the coronary care unit.
- We observed on the ICU that there were blood splashes left on the blood gas machine and it was not cleaned after use, which put people at risk of cross-infection. A failure to clean the blood gas machine after each use was also identified in the trust's previous infection control report as a risk to patients and staff.
- We observed a staff member use the blood machine without using gloves. This puts people at risk of infection. The nurse in charge was made aware of this and it was to be addressed.
- We saw that the cleanliness of each unit was audited. The outcome of the audit was prominently displayed for patients, relatives and staff. The ITU, HDU and coronary care unit had scored 100% cleanliness when audited by an independent manager.
- Results of monthly staff with hand washing/hand hygiene audits identified that the ITU, HDU and coronary care unit had scored 100% compliance. Staff followed the trust policy on infection control. The 'bare below the elbow' policy was adhered to and hygienic hand-washing facilities and protective personal equipment such as aprons and gloves were readily available. We observed that aprons were colour-coded for each bed space to easily identify if staff did not change their aprons if they needed to assist other patients, which is good practice.
- Hand gel was available at the entrance to each ward/unit we visited and at each bed space. We observed that the position of some hand gels was difficult to access in some areas of the ICU unit. We observed that staff had to stretch behind a curtain behind a patient's bed to use one hand gel. If hand gels or hand-washing facilities are not accessible, this increases the risk that they may not be used and put people at risk of cross-infection.
- Signs were visible throughout the units to remind staff and visitors about the importance of hand washing.
- We observed that intravenous medicines were being prepared by staff on a work surface behind the nursing station. This work area was also used to put patients' notes on and other activities that were not associated with intravenous medication practice. This work area could not be effectively cleaned and staff practice did not comply with aseptic non-touch technique, and may put patients at risk of infection.
- The unit is part of the Scheduled Care Management Group. The group risk register identified that the ICU does not comply with core standards for intensive care for air flow within the side wards to protect patients from the risk of cross-infection. This standard was published in 2013 and it is expected that trust will be working towards achieving this. Action required was identified in the group risk register as a new ICU once capital is available, with an implementation date of 31 December 2016.

Environment and equipment

- There was limited space available within the ICU. The scheduled care group risk register identified that the ICU does not comply with national ITU standards for bed space and this poses a risk of cross-contamination if patients are too close together. Actions required are identified as a new ICU once capital is available, with an implementation date of 31 December 2016.
- To ensure patient safety, appropriate safety checks on equipment were undertaken. For example, we observed checks to portable capnography used to check the location of breathing tubes by monitoring carbon dioxide in expired breath.

Critical care

- We saw that the resuscitation equipment was regularly checked and when needed restocked; there was a record of when and who had undertaken this check.
- A buzzer system was used to enter the ICU and the HDU to identify visitors and staff and ensure patients are kept safe.

Medicines

- All controlled medication, high-risk medication and associated paperwork were appropriately and safely stored.
- Medicines and intravenous fluids were securely stored in lockable cupboards.
- The medicines' fridge temperatures including the minimum and maximum temperatures were recorded daily.
- The temperature of the room/area where medicines were stored was not recorded within the wards/units we visited. A regular check on temperature provides assurance that medicines are stored safely and their effectiveness is not adversely affected.
- The ICU and HDU had a dedicated senior pharmacist who provided advice and support to the units.

Records

- The ICU, HDU and coronary care unit used a combination of computerised and paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient and their treatment and care needs.
- The coronary care unit used "Patient Safety at a Glance" computerised records. This system enabled staff to clearly see the patient's treatment plan and progress and also to show that referrals had been made to other professionals. Patients' observations were also recorded on this system.
- Within the ICU and HDU nursing documentation was available at each bed space. Observations were checked and recorded at the required frequency and when required were escalated to medical staff.
- There were clear records of the treatment patients had received and any further treatment or follow-up they required.

Safeguarding

- Staff confirmed that they had received safeguarding awareness training and confirmed actions that would be undertaken to keep people safe. Staff were aware of their safeguarding responsibilities.

Mandatory training

- Training information provided by the trust showed that 66% of nursing staff in coronary care had received mandatory training and 86% of nursing staff in ICU and HDU.
- Staff told us during the inspection that staffing shortfalls had made it difficult for them to attend required mandatory training and the annual mandatory training updates.
- Staff training and attendance was monitored both by the ward manager and senior managers.

Management of deteriorating patients

- There was a critical care outreach team (one nurse each day) seven days a day week from 07.30 till 20:00 for the management of critically ill patients in the hospital.
- The hospital used the VitalPAC early warning score (VIEWS) escalation process for the management of acutely unwell adult patients. VitalPAC is a computerised assessment tool used to identify patients who were deteriorating.
- The VIEWS score alerted doctors and the critical care outreach team which patients were deteriorating and needed to be reviewed urgently. We saw that this ensured that's staff provided early and appropriate treatment.
- Nursing handovers occurred twice a day. Staff told us that as they were a small unit they were able to communicate any changes to patients or other risks to other staff easily.
- Risk assessments for patients for pressure ulcers, falls and VTE were being completed appropriately and reviewed at the required frequency. Risks assessments identified required actions to minimise risks to patients.

Nursing staffing

- We found at our inspection visit that nurse staffing numbers potentially compromised patient safety in ICU and HDU and did not meet Core Standards for Intensive Care Units. Nurses were allocated to provide one-to-one care for level-three patients and for one nurse to provide care for up to two level-two patients.

- However, a lack of supernumerary nurses meant that nurses often had to leave level-three patients (patients who were most ill and were ventilated) to assist other staff, which put patients at risk. The core standards identify that the clinical coordinator should be visible and accessible to staff, patients and relatives. We fed back our concerns to the trust and sent them a letter after our inspection visit to highlight the issues we identified. The trust took immediate action to ensure that a supernumerary nurse was available 24 hours a day and core ICU standards were being met. We re-visited the unit as part of our unannounced inspection and confirmed that the situation had been rectified.
- To maintain safe staffing levels, the ICU/HDU relied on temporary staff such as bank and agency nurses. Nursing staff told us that the trust had a policy that agency nurses could not administer intravenous medicines without supervision from a permanent member of staff. This meant that staff had to leave the level-three patient they were looking after to check and administer intravenous medicines with the agency nurse. However, since the trust has ensured that a supernumerary nurse is available 24 hours a day, this scenario has occurred less frequently and so has reduced the associated risks to patients.
- We were told it was planned for a senior nurse on day shifts (band six or seven) to be supernumerary, but there was no plan for a senior nurse on night duty to be supernumerary. However, we found that there was often no supernumerary nurse on the day shifts either. Band six nurses we spoke with confirmed there was frequently no supernumerary nurse available. Core standards for intensive care units identify that: 'A clinical coordinator should be on duty for units over six beds to provide clinical nurse leadership and provide support and supervision to optimise safe standards of patient care'.
- We visited the ICU and HDU as part of our unannounced inspection and found that staffing levels were safe. However, long-term staffing plans were yet to be established and the matter is being kept under review.
- Nurse staffing levels for the coronary care unit met national standards for coronary care. There were two nurses on duty 24 hours a day, with a healthcare assistant available on day shifts to provide care for up to eight patients and oversee the telemetry of up to eight patients on the adjoining ward. Staff told us that there were sufficient and appropriate staff available for patients.

Medical staffing

- Medical care in the ICU and HDU was led by a team of six consultants who were intensive care qualified. One consultant was present on the units from 8am to 5pm five days a week. This meets core intensive care standards of no more than 14 patients to each consultant.
- The consultants on ICU and HDU undertook ward rounds twice daily, Monday to Friday. Out-of-hours at weekends and nights there was an on-call consultant rota to provide cover in critical care, but they might not be an intensive care specialist. The core standards for intensive care units identifies: 'A Consultant in intensive care medicine must be immediately available 24/7, and be able to attend in 30 minutes'. The unit was not these meeting standards.
- Assurance was required that formal intensive care ward rounds take place at the weekend and on bank holidays. Consultants we spoke with told us that decisions were sometimes delayed until ICU consultants were available. This meant that there was a risk that patients may not receive timely treatment and thus does not meet core intensive care standards.
- Potential admissions were discussed with a consultant. Patients were mostly reviewed by the consultant within 12 hours of admission, although this could not be assured over the weekend. This does not meet intensive care standards.
- A registrar or middle-grade doctor with intensive care experience was on duty between 10pm and 8am for ICU and HDU. In addition, one consultant was on-call from home.
- The coronary care unit had appropriate consultant cardiologist cover. A consultant cardiologist provided medical cover on-site for the coronary care unit Monday to Friday and then one day over the weekend. On day seven a cardiology consultant was on-site at Princess Royal Hospital and was contactable by phone, but would visit the hospital if required.
- A registrar provided medical cover for the coronary care unit overnight. A consultant was on-call from home.

Critical care

Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. Staff we spoke with were familiar with their role within the major incident plan.

Are critical care services effective?

Good

There was effective evidence-based practice and multidisciplinary working in critical care services.

Seven-day working for some staff and services was being developed, but further development was required, such as pharmacy services. The availability of an intensive care consultant over the weekend was insufficient to ensure that patients received appropriate review. There were appropriately experienced nurses in ICU, HDU and the coronary care unit. However, the lack of a dedicated nurse for education did not meet core standards for intensive care to develop and improve nurse practice.

Evidence-based care and treatment

- The ITU and HDU units used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidance to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- The unit had an identified clinical audit programme to monitor adherence to guidance, and staff were delegated responsibility to carry out audits. For example, hand hygiene, commode cleanliness and general cleanliness audits identified appropriate compliance.

Pain relief

- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us that staff ensured they had the pain relief they needed and were kept comfortable.
- There was no pain assessment score for patients who were unconscious or were unable to express pain for use by staff. This meant that these patients may not receive appropriate pain relief.

Nutrition and hydration

- Approximately 50% of patients we spoke with said they did not like the hospital's food.
- We observed that when needed staff offered patients assistance with eating and drinking.
- Patients all agreed that they had a choice of drinks and they were regularly offered to them. We observed that drinks were accessible to patients.
- Patients who were unable to eat or drink received nasogastric feeding within 24 hours of their admission to ICU and HDU.
- Staff reviewed records to ensure that there were appropriate arrangements in place to highlight the risk of dehydration.
- Dietetic advice was sought when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were whenever possible asked for their consent to procedures appropriately and correctly. Patients who were able to speak to us were able to confirm that they were asked to give permission for treatment.
- Frequently intensive care and high dependency patients may be unconscious or may be unable to provide their consent. Staff were able to provide examples of patients who did not have capacity to consent, how they acted in the patient's best interests and whenever possible consulted with their relatives. We found that The Mental Capacity Act 2005 was adhered to appropriately.

Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. ICNARC data showed that the hospital had a lower death rate when compared with other similar trusts.
- The ICNARC data demonstrated that the hospital's ICU and HDU performed better in most outcomes assessed (such as infection rates and unplanned readmissions) than other similar trusts. The areas in which the trust performed worse were: patients who were discharged to another critical care unit in another hospital for a non-clinical reason; patients whose discharge was delayed for more than four hours; and out-of-hours transfers from the unit.
- This meant that patients who were very ill had to be moved to another hospital because no suitable bed was

available at Royal Shrewsbury Hospital, patients were kept within the ICU/HDU for longer than needed and may mean that a bed was not available for another patient.

Competent staff

- The core standards for intensive care require that 50% of nurses in critical care should have a postgraduate qualification. The hospital had 58% of nursing staff with this qualification. On the day that we visited only two of the six qualified nurses on duty in ICU had a critical care qualification, and one additional nurse was currently undertaking this qualification. This meant that there was a risk that staff on duty may not have the skills or experience to provide effective care to patients.
- The nurse in charge of the coronary care unit had a coronary care qualification, which meets best practice guidance.
- Nursing staff had an induction period during which they were supernumerary for up to four weeks to ensure they were familiar with procedures and practices on the units.
- All nurse competencies were checked by nurses against standards identified by the National Competency Framework for Adult Critical Care Units. Senior nurses told us that they had struggled to complete the required competency assessments because of staffing shortages.
- Staff told us that they did not have a clinical care education development nurse, although this need had been identified. Staff said that this role was undertaken by senior staff around their other commitments. The lack of a clinical care practice development nurse means that the trust does not meet intensive care nursing core standards.
- We spoke with doctors who said they felt supported, and were observed to have excellent rapport with patients and other staff.
- 84% of staff in ICU/HDU and 90% of staff in coronary care had received an annual appraisal. Staff we spoke with confirmed that they had received an annual appraisal.

Multidisciplinary working

- There was a daily ward round with input from nursing staff. Multidisciplinary team members such as physiotherapists, the pharmacist and speech and language therapists had a handover when they visited the unit.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy.
- Patients had an assessment of their rehabilitation needs, which was usually undertaken within 24 hours of admission to the unit, as required by best practice guidelines.
- The unit shared a team of 3.9 whole time equivalent physiotherapists with other wards. A physiotherapist visited twice daily to plan and deliver treatment to patients.
- All patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietician provided support to the units.

Seven-day services

- A physiotherapist was on duty at weekends, but they also covered other wards and their availability was limited.
- Radiology services were available for urgent x-rays and scans.
- The pharmacy was open on Saturday mornings but not on Sundays. Outside of these times an on-call pharmacist was available. Staff said that pharmacy arrangements were not effective and required improvement.

Are critical care services caring?

Good

Patients and their relatives we spoke with said that staff were caring and compassionate. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients we spoke with were highly complimentary about all the staff in ICU, HDU and coronary care. Relatives also told us that staff were caring and compassionate.
- There were appropriate arrangements in place to maintain patients' privacy and dignity. There were

privacy screening/curtains around each bed space, with a note to remind staff to ask before they entered. We also observed staff trying to maintain the dignity of a confused and agitated patient by ensuring they were covered by bedding and their hospital gown.

Patient understanding and involvement

- The nature of the care provided in a critical care unit meant that patients could not always be involved in decisions about their care. However, whenever possible the views and preferences of patients and their relatives were taken into account.
- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes. On the HDU we saw a nurse spending time speaking with a patient who had difficulties speaking to ensure they had understood their treatment plan.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support.
- A chaplaincy service provided valuable support to patients and relatives.
- Relatives we spoke with said they had mostly been updated by staff and had opportunities to have all their questions answered by the consultant.

Are critical care services responsive?

Requires improvement

The critical care services required improvement to meet patients' needs. The hospital was challenged with the availability of beds, both throughout the hospital and within critical care services. There were occasions when patients had to wait for a suitable bed in critical care services. In addition, a delay in the availability of suitable beds on other wards had given the units other challenges.

Access and flow

- Between 1 August 2013 and 31 August 2014, figures showed bed occupancy in ICU/HDU was 86%, which is the same as the national bed occupancy. The bed occupancy is also above the Royal College of Anaesthetists' recommended critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers that carry associated risks.
- The bed occupancy for coronary care was 99%.
- ICNARC data showed that
- the number of non-clinical transfers from the hospital's critical care unit ICU and HDU to other hospital's critical care units for non-clinical reasons was worse than the national average
- the critical care unit performed worse than the national average for out-of-hours discharges
- the critical care unit performed worse than other comparable units for patients whose discharge from the unit was delayed for more than four hours.
- Between October 2013 and September 2014 there were 11 operations cancelled because of lack of availability of critical care beds (this may include ICU and HDU).
- Staff said that they frequently struggled to discharge patients to wards. Staff told us that patients were often discharged to a ward as a 'swap' when the bed was needed by another ward patient.

Meeting people's individual needs

- The ICU and HDU units provided care to people with complex needs. Staff told us that if they had a patient with additional needs such as a learning disability, mental health difficulties or dementia, additional support was made available.
- Translation services were available both by phone and in person.
- Staff demonstrated a good understanding of people's social and cultural needs
- The unit sometimes has difficulty discharging patients to the wards as there is no appropriate bed available. This poses a challenge to the trust when it comes to eliminating mix sex accommodation. When patients no long need level 2 or 3 care they should be immediately placed on an appropriate ward. Failure to do so is a breach of these guidelines.
- Difficulties discharging patients who no longer required ICU/HDU care meant that the hospital was challenged to comply with single-sex ward areas and bathroom and toilet facilities because patients of different sexes could be accommodated in the same area.

Critical care

- There were identified visiting times. Flexible visiting time was at the discretion of the nurse in charge for new admissions and patients who were at the end of life.

Learning from complaints and concerns

- We looked at two recent complaints received about the coronary care unit. We saw that complaints were investigated and the outcome of the complaint recorded with any learning identified. The ward managers told us that complaints were discussed with the ward teams.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the shift leader. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Complaints posters were displayed within the ICU, HDU and coronary care units, informing patients and relatives how to complain if they were unhappy with their care and treatment.

Are critical care services well-led?

Requires improvement

Critical care services required improvement to demonstrate they were well led.

Managers on the unit were clear about the core standards and the risks associated with the services they managed. However, there was an apparent lack of understanding of the requirements and importance of core standards for ICU/HDU and coronary care by matrons and senior managers from outside the ICU/HDU and the coronary care unit. During our inspection we identified a number of aspects of the service which were not meeting the national core standards. These risks had not been reported by managers and there were no places in place to rectify the situation. The lack of required actions to ensure that core standards were met had compromised patient safety.

Staff did not feel listened to and were not confident that required actions would be taken in response to the risks identified.

Vision and strategy for this service

- Staff were aware and understood the vision and values of the trust. Staff were clear about their role and behaviours that would achieve these values.
- Changes to the service because of challenges of providing two ITU/HDU units at Princess Royal Hospital and Royal Shrewsbury Hospital were under consideration by the executive team.
- Changes to the provision of coronary care services and diagnostic testing (angiograms) were in place to provide a cost-effective service.

Governance, risk management and quality measurement

- The scheduled care group had monthly governance meetings where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff.
- Some but not all risks inherent in the delivery of safe care were identified on the scheduled care risk report. However, the lack of timely actions to address these risks did not provide assurance that actions were being taken to protect people from avoidable harm.
- The ICU and HDU managers encouraged staff to report incidents. Changes to feedback arrangements were needed to improve staff confidence in the process.
- A root cause analysis was undertaken following each serious incident, the investigations undertaken were detailed and actions identified to reduce the risk of further similar incidents in the future.

Leadership of service

- ICU/ HDU and coronary care were within different divisions and had different leadership and management arrangements. ICU/HDU and coronary care each had a consultant who was the medical clinical lead.
- ICU/HDU had a matron (band eight) who also covered theatres, recovery and trauma and orthopaedics. The matron did not have a specialist qualification in critical care. This does meet the intensive care core standards.
- There was an apparent lack of understanding of the requirements and importance of core standards for ITU and HDU by managers from outside the ICU and HDU units.
- A band six or seven nurse was in charge of each shift on ICU and HDU and coronary care, but this role was usually in addition to providing direct patient care and

was not supernumerary. Core standards for intensive care identify that there should be a clinical coordinator on duty 24/7 who is supernumerary to provide clinical leadership and supervision.
- The ward managers and matron we spoke with said that they were supported by the divisional management and executive team and felt that the director of nursing was approachable and supportive.
- Most staff reported that their matron was visible and approachable.
- Each shift was led by a band six sister with supervisory responsibility for the staff working with them.
- Staff said that the when they did not have a supernumerary nurse in charge, the leadership of ICU/ HDU was challenged. Since our initial visit there is now a supernumerary nurse on duty 24 hours a day and staff were more positive about leadership arrangements.
- Both units had cost improvement programmes. Initiatives that were in place to identify cost improvement included a review on the use of the most frequently prescribed medications.

Culture within the service

- Staff felt that their values for quality care were being compromised because of staffing challenges.
- Staff working on ICU, HDU and the coronary care unit spoke positively about the service they provided for patients.
- Staff were encouraged to complete incident forms or raise concerns. Staff felt that these concerns were not adequately addressed or listened to by senior managers from outside the units.

Public and staff engagement

- Staff said that they felt that senior managers from outside their wards/units had not listened to their concerns. Staff we spoke with did not feel actively engaged in decisions about their service.
- Several staff we spoke with told us they had identified improvements that were needed such as staffing arrangements. They had shared their concerns with senior managers from outside the unit, but it was not clear whether these had been suitably escalated to the executive team.
- Staff said that they spoke with patients and relatives about their views on the units. There was no formal system in place to capture people's views on the service provided.

Innovation, improvement and sustainability

- There were systems in place to encourage innovation and improvement from staff members across all disciplines. We saw that staff could be nominated for awards for their achievements and there was an annual awards ceremony. Staff on the coronary care ward had recently been thanked for their achievements and had received a box of chocolates in recognition. Staff who received these awards had their photograph and achievements recorded in the staff magazine.
- There were appropriate systems in place to review service delivery and when needed ensure that lessons were learnt and appropriate actions taken.
- Staff and senior managers told us that the hospital had been financially disadvantaged in the past, which was a challenge to improving the quality of service delivery.
- Staff said that just their normal duties were a challenge with current staffing difficulties. We recognised that the sustainability of improvement was a considerable challenge.

Maternity and gynaecology

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

Information about the service

The Midwifery-Led Unit (MLU) at Royal Shrewsbury Hospital had 367 deliveries in 2013/14 and 136 deliveries for 2014 as at the end of August. Until 30 September 2014, the consultant-led service was also based at Royal Shrewsbury Hospital but was then transferred to Princess Royal Hospital as part of the reconfiguration. Gynaecology inpatients services had also moved to the Princess Royal Hospital, whilst fertility services remained at the Royal Shrewsbury site..

The unit has two labour rooms as well as a birthing pool. There were 13 beds made up of a combination of bays and side rooms. The MLU accepted women who had been assessed as low risk and suitable to deliver their baby there. Some women who booked and attended to deliver their baby at the MLU were transferred during labour if complications arose.

The MLU also cared for women who had delivered at the consultant-led unit, now based at Princess Royal Hospital, if they required additional support, for example with breastfeeding.

During the day there were two midwives on duty and one women's service assistant. They were supported by two community midwives during the day and two midwives on-call at night. The unit had a manager who worked office hours.

There was a Day Assessment Unit. Outpatient visits were held daily for antenatal and postnatal women, which included a consultant-led clinic. We inspected all operational areas of the MLU, antenatal clinic and day assessment unit. We spoke with six members of staff, two patients and reviewed two sets of notes.

Maternity and gynaecology

Summary of findings

The consultant-led unit had recently moved to Princess Royal Hospital because Royal Shrewsbury Hospital did not comply with structural building standards, the trust had deemed it unsuitable for long-term use.

We saw that the MLU was well staffed and women were very satisfied with the care that they had received. Staff knew how to report incidents but felt feedback could be improved. They had access to all the necessary equipment and felt well supported by their managers. The unit regularly audited its services to ensure they were effective and there was good multidisciplinary working. Staff were very caring and were able to respond to individual needs. Staff were not aware of a vision for the service beyond the recent restructure and the reporting of some performance data could be clearer.

Are maternity and gynaecology services safe?

Good

We found that the maternity service at the MLU was good. Staffing levels were safe, although a formal clearly defined protocol for on-call arrangements was not in place.

The trust had a system in place to report incidents. The staff we spoke with were not aware of any shared learning from incidents, with exception of one serious incident that had occurred at another unit five years previously.

Mandatory training had well attended for most courses but the report we were provided with did not include training data for courses specific to midwifery such as cardiotocography training or provide data at unit level.

We found that infection control arrangements were good and the unit appeared visibly clean on the day of our inspection.

Incidents

- The midwife led unit at Royal Shrewsbury Hospital opened on 1 October 2014. The data were provided on incidents did not relate to the new unit.
- The hospital reported a total of 1,234 incidents between July 2013 and July 2014 for maternity and gynaecology. This included all incidents from the consultant-led service, gynaecology and the MLU.
- There were no Never Events reported by the trust. A Never Event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented.
- Management informed us that all staff had access to report incidents on Datix, the trust's IT-based reporting system, and that regular reporting of incidents took place.
- We selected a random sample of incidents reported during the preceding 18 months; we noted that not all incidents had been categorised and that some incidents had been categorised as low when it would have been appropriate to categorise them as moderate or high. We requested an explanation from the trust about this and

were provided with a spreadsheet that reported on the number of incidents and whether they had been reviewed and approved. However, an explanation was not provided.
- The staff we spoke with informed us that they would report an incident if it occurred. They also told us that they did not receive feedback on lessons learned from incidents unless they had been directly involved.
- We were aware of a serious incident that had occurred at another MLU at the trust five years before. We saw that changes had been made as a direct result of this incident and the staff we spoke with were all aware of the changes. It was noted that not all of the issues identified during the incident had been fully addressed. For example, it had been identified that there had been an issue with checking and recording the baby's temperature. The documentation completed by staff had not been revised to include a specific prompt to record temperature, placing reliance on the midwife to remember to do so.
- The Women and Children's directorate produced a quarterly newsletter that included information about lessons learned from incidents. The staff we spoke with did not mention this newsletter and we did not see it displayed in the unit.

Safety thermometer

- We saw that overall performance was good and low or zero incidents of falls and pressure ulcers. Completion of risk assessments for VTEs had been above 90% since April 2014.

Cleanliness, infection control and hygiene

- We observed that Royal Shrewsbury Hospital MLU appeared visibly clean and we saw staff regularly wash their hands and use hand gel. The hospital's 'bare below the elbow' policy was also adhered to.
- There had been no reported cases of MRSA or MSSA bacteraemias for 2014/15; data provided was reported until the end of July 2014.
- Data for hand hygiene, peripheral line care, decontamination and commode cleaning demonstrated positive results in recent months.

Environment and equipment

- The staff we spoke with told us that they had enough equipment; and that in the event of equipment being faulty this was replaced and/or repaired promptly.
- We reviewed the resuscitation equipment and found that there were a small number of items that were out of date. We informed the manager, who confirmed they would be replaced.

Medicines

- We observed that medication was stored appropriately. From the sample of medication we reviewed, including controlled drugs, these had been recorded as administered in accordance with requirements.

Records

- We observed that patient records were stored securely.
- All women were issued with a copy of their care plan, which they retained and took to appointments throughout their pregnancy.
- We reviewed a sample of patient records and found that they had all been completed with relevant clinical information and signed and dated in accordance with guidelines.

Safeguarding

- The staff told us they had attended safeguarding training. The data provided showed that training attendance at level-three child safeguarding for clinical services staff and midwives had been well attended. Training for adult safeguarding had been attended by 63% of midwives and 71% of all other staff.
- The staff we spoke with were able to describe with confidence the types of incidents/signs that would give them cause for concern about a child or vulnerable adult's welfare, which may prompt a safeguarding concern.
- The trust had arrangements in place to report safeguarding concerns through an 'alert' and/or referral to social services. It is the line managers responsibility to decide who makes the referral, as well as ensuring other guidance is followed, as set out in the trust's policy.
- The staff we spoke with told us that if they were the first person to identify a concern, they would call the midwife safeguarding lead. Out of hours they would call social services and that this would be followed up with a faxed referral.

Mandatory training

- All staff were required to attend mandatory training. We were told that the mandatory training requirements had been needs-assessed and tailored to ensure

professional updates and clinical skills were relevant to the staff member, according to their speciality and location. For example, midwives working at MLUs had additional life support training for neonates.
- The data provided showed that some mandatory training had been better attended than others, for example, attendance at hand hygiene training had been good, but infection prevention and control training attendance was low. Adult basic life support had been completed by 63% of all midwives and 64% of other staff; there was no data recorded for paediatric life support attendance.
- We noted in the Quality and Safety Report 2014 that it stated 70% of all midwives had completed newborn life support training. However, data was not broken down at location level, therefore we could not determine if midwives and other staff working at Royal Shrewsbury Hospital had completed it.

Management of deteriorating patients

- The department used early warning scores to monitor any potential deterioration in a woman's condition.
- We talked to midwives and women's service assistants about providing life support to a mother or newborn baby. All of the staff we spoke with confidently described how they would perform resuscitation.

Midwifery staffing

- During the day there were two midwives on duty and one women's service assistant in the main MLU, they were supported by two community midwives for 7.5 hours each day who would attend the unit as necessary. Outside of these hours there were two midwives on duty with support from a women's service assistant; two midwives worked on-call to support with deliveries as the need arose. The unit had a manager who worked office hours. There were additional staff working in the Day Assessment Unit and Early Pregnancy Unit as well as the antenatal clinic.
- We were told that the maternity department did not use agency midwives and that cover was always sourced internally through additional shifts for permanent staff or using the bank.
- The staff we spoke with told us that since the consultant-led service had moved to Princess Royal Hospital, staffing was stable and they felt able to cope with the level of demand. They were able to offer all women received one to one care in labour and there were always two midwives present at delivery.
- During the night shift, on-call cover was provided by two midwives. We were told that the distance each midwife lived away from the unit varied, but that calls were made in sufficient time should a second midwife be required.

Escalation Policy

- The trust had an escalation policy in place that outlined optimal and sub-optimal staffing levels. There was an appendix describing conditions where the escalation procedure may need to be followed.

Are maternity and gynaecology services effective?

Good

Maternity services were judges as effective. We noted that there were arrangements in place to audit the care and services provided. We saw that women received pain relief as required and adequate arrangements were in place to ensure women and their babies received nutrition and hydration.

Overall outcomes for women were good, although some outcomes were not consistently achieved and the data was not always clearly reported. Data was also not reported on by location, which meant it was not possible to observe performance at a particular site.

Evidence-based care and treatment

- The trust had an Assurance Midwife who had responsibility for ensuring all new standards and published guidelines are reviewed and implemented. We were told that all new NICE and ROCG guidance is reviewed by the Assurance Midwife and benchmarked against the trust's current arrangements. A report is prepared for the governance committee, detailing the differences between the new guidance and current trust standards. The committee then discuss and agree any changes that need to be made.
- We reviewed care pathways and two patient records. We found them to be compliant with the associated standards and local procedures.

- The staff we spoke with told us that they regularly received updates regarding changes to guidelines and that these were also available on the intranet.
- A women and children's clinical audit plan was prepared annually; audits were completed by medical staff throughout the year. We reviewed the plan, which included local and national priorities. We saw from review of the plan that audits were of relevance and were in progress.
- The trust had an audit midwife responsible for overseeing assurance audits, which were undertaken by midwifery staff and separate to the clinical audit process. We were told that a review of both audit plans was undertaken to ensure there was no duplication.
- We reviewed a sample of assurance audits and saw that they clearly stated aims, objectives and findings. A re-audit, 'Audit of Care of Women in Labour', reported a small decrease in performance of staff in three individual elements of maternal observations in second stage labour. The recommendation was to address this with individual staff; however, there was no evidence that recommendations were shared with all staff to ensure generalised learning. Findings had not been reported on by location.

Pain relief

- The women we spoke with all told us that they had received appropriate pain relief.
- The staff we spoke with informed us that there were never any issues in providing the required pain relief for women and that this was done in accordance with their wishes and clinical appropriateness.

Nutrition and hydration

- The women we spoke with were satisfied that they had received adequate meals and hydration.
- We noted the unit did not have facilities to support women to make up their baby's bottle feed, if choosing to feed their baby on formula milk. Mothers were expected to bring in a 'ready-made' formula, although there was some 'ready-made' formula available if they had not brought their own. This meant some mothers were not receiving direct support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained for procedures as required. The trust had set procedures for assessing someone's capacity. We talked to staff and were told that a person's mental capacity was assessed as required and that this was documented.

Patient outcomes

- The maternity department maintained a Quality and Performance Dashboard, which reported on activity and clinical outcomes. Data was reported on at a trust-wide level and by clinical commissioning group (i.e. which authority funded the woman's care). Activity by location was reported, but not performance.
- Overall clinical performance was equal to or above expected performance, with the occasional exception by month; for example, we noted that the rates of third- and fourth-degree tears for first-time mothers was higher than expected for July.
- The dashboard used a RAG (red/amber/green) system of reporting actual performance against the expected. The thresholds for achieving these targets were not clear. For example, for access to maternity services; there was a target of 90% for the percentage of bookings with a gestation of less than 12 weeks 6 days. We saw that achievement for one of the months was coloured red and the percentage achievement recorded, and for other months was coloured amber. Also, the target for the 'overall normal birth rate' was set at 70% for two of the five months reported on; the outcome achieved was less than 70% but was coloured green. This was the same for assisted birth rates. This meant that the data reported in this format could not be relied on.
- We noted that the clinical outcome for women from Powys Local Health Board was significantly poorer for the percentage of normal births for quarter 1 at 56% compared with all women who used the trust services where this was 69%, there was an improvement for quarter 2 but this remained lower for Powys women. We also saw that assisted births for Powys women was 14% for the year to date compared to 7% for all other women. The forceps rate was also much higher for individual months for example in April the rate for Powys women was 15.8% and 11.1% in August compared to 4.6% and 7.9% for all women during the same months; A 0% forceps rate was achieved for one month for Powys women, which then made the year to date figure

comparable with other women. We also saw that the induction rate, third- and fourth-degree tear for first-time births; the still birth rate were also much higher for three of the five months.
- One-to-one care in labour was reported at 87.3% for the year to date (until August) for Shropshire and Telford and Wrekin.
- The dashboard did not report on maternity readmission rates or unexpected admissions to NICU or unexpected maternal admissions to ITU, one to one care in labour and the ratio of midwives to births. It also did not report on the transfer rate of women from MLUs to the consultant-led service. This information is helpful for review at a glance, to ensure a full perspective of the service is monitored each month.
- We requested data on the transfer rate of women being transferred from MLUs to the consultant-led service. We were only provided with percentages of women who had delivered at the consultant-led unit instead of their intended unit. Data was broken down by the stage of pregnancy at which they changed their mind or a clinical decision was made. The reasons were also reported on; however, it was not entirely clear for all categories whether this was during labour.
- Access to maternity services was consistently below the 90% target for the percentage of bookings with a gestation of less than 12 weeks and below the 75% target for the percentage of patients with access to the same midwife throughout their pregnancy.

Competent staff
- The staff we spoke with all told us that they had received their annual appraisal and supervision and that they found this process helpful. We saw that trust-wide data reported 97% of staff had completed their appraisal by August 2014.
- To ensure all midwives have had their competencies maintained up to date, the trust has reviewed and revised its 'rotation' arrangements for midwives. Previously a proportion of midwives rotated from MLUs to the consultant-led unit to update their skills; each rotation lasted one year. This arrangement had been in place for over 30 years. There had previously been no consistency in the selection process and therefore not all midwives rotated.
- We were told that the trust had recently developed a database of all midwives to review when they had last 'rotated' to improve this process. From 2015, there will be two rotations each year for a period of three months each; rotations will be structured to ensure all midwives complete a rotation.

Multidisciplinary working
- The staff we spoke with reported good multidisciplinary team working, both internally and externally.
- We were told that external arrangements also worked well and that there were good communications and links with local GPs as well as social service. Information was regularly received from social services on individuals and specified any support they may be receiving or may need.

Seven-day services
- Out-of-hours services were available in emergencies. All women could report to the main hospital in an emergency either through A&E or maternity reception. The maternity unit had scanners available, which could be used out of hours if necessary. During the day there was an Early Pregnancy Assessment Unit or Day Assessment Unit. Guidance on self-referral or GP referral was provided at their first appointment.
- We were told that the pharmacy service was available out of hours using the on-call system if necessary.

Are maternity and gynaecology services caring?

Good

Women who attended Royal Shrewsbury Hospital MLU received good care. The women we spoke with told us that staff were very caring and that information had been explained to them about their treatment.

Compassionate care
- The women we spoke with reported that they received a good standard of care from all members of staff.
- Feedback in the CQC maternity survey results reported positive findings overall for each aspect of maternity care provided.

Patient understanding and involvement
- The women we spoke with reported that communication was good throughout their pregnancy and that their partners had been involved.

Maternity and gynaecology

Emotional support

- The trust had a bereavement midwife who worked at Princess Royal Hospital and was responsible for speaking with women and their families who were bereaved during or after childbirth or required a termination for medical reasons. The midwife offered support and advice to women and their families at specific stages, but could be contacted if needed. Information detailing various agencies who provide counselling support for women and their families was also provided.
- Women who suffered a miscarriage or bereavement during their pregnancy or if they required a termination for medical reasons were all referred to Princess Royal Hospital to receive their care and treatment.

Are maternity and gynaecology services responsive?

Good

Maternity services were responsive. We found that planning and delivery was good and that access arrangements worked well. In general people's individual needs were met, and arrangements were in place for people whose first language was not English. Complaints were responded to and lessons learnt.

Service planning and delivery to meet the needs of local people

- We requested a copy of the department's business plan, although this was not provided. We were therefore unable to ascertain how the service was planned to meet the needs of local people. We were told by staff that they were able to meet the needs of local people. It was unclear how this had been assessed as part of a forward planning exercise.

Access and flow

- The number of deliveries per month averaged around five and the unit could always accommodate women who needed additional support for their postnatal care if they had delivered at Princess Royal Hospital.
- The trust had a set target of 90% for women making a booking with a gestation of less than 12 weeks and 6 days. This was being met for the majority of months, with the exception of teenage pregnancies where performance varied from 69% to 86%.

Meeting people's individual needs

- We were told that women who used the service who were unable to speak English fluently could access an interpreter service if required. An interpreter could be booked to attend antenatal appointments if necessary; a telephone service was also available. The staff we spoke with reported that this worked well when needed.
- There were information leaflets available in other languages if required. Leaflets in alternative languages were those made available by the Department of Health; these were accessible to staff using the intranet and could be printed for women as required.
- The staff we spoke with told us that if a patient who used the service had any specific needs, whether these were mental health, social needs or safeguarding, they would contact the trust safeguarding lead or refer to guidance on the intranet for advice.
- A multidisciplinary meeting was held monthly to discuss midwifery patients with additional support needs to ensure their individual care plan was suitable.

Learning from complaints and concerns

- We observed a combined Patient Advice and Liaison Service and complaints leaflet was available for patients who may want advice and support.
- We reviewed complaints related to Royal Shrewsbury Hospital between August 2013 and July 2014. There were a total of 14 complaints for gynaecology, five of which were recorded as no action required. The majority of complaints related to communications or delays in receiving treatment. All complaints were responded to within the deadline agreed by the trust.
- There were 23 complaints for obstetrics, seven of which were recorded as no action required. The majority of responses included sufficient information recording the outcome and action taken.

Are maternity and gynaecology services well-led?

Good

The MLU at Royal Shrewsbury was well-led.

There was a governance structure in place and arrangements for patients to provide feedback. Staff felt well supported by their immediate line manager but felt supported by senior management could be improved. The

directorate had recently accomplished a major restructure of the service, moving obstetric led services to a new unit based at the Telford site. The vision for the next steps for maternity services was not yet clear.

We saw some positive examples of good governance, but we noted that reporting of data was unclear and could potentially be misleading, and minutes of discussions about performance could be improved.

Vision and strategy for this service

- A Maternity Services Review was commissioned by the two local clinical commissioning groups in October 2013 following increased concerns over the service. The review focused on patient safety, quality of care, the sustainability of the hub-and-spoke model and the sustainability of workforce numbers, alongside educational needs, the reporting of serious incidents, patient complaints and review of serious incidents. The review also considered the areas highlighted by the coroner following the outcome of an inquest into the death of a newborn baby within the county. Opinions of mothers who had received care, their partners and family members were also sought. The review identified areas for development and implementation. The report reflected that the hub and spoke approach to maternity care was safe and of a good standard however five areas of recommendation were made. These included care of neonates, improved governance processes, the development of a strategy and increased public engagement. This was approved in April 2014 and we saw that progress had been made with its implementation.
- We requested a copy of the business plans for the service. However, this was not provided.
- The staff we spoke with were not as yet aware of what the vision was for the service beyond the recent reconfiguration.

Governance, risk management and quality measurement

- There were clearly defined committee arrangements in place. The directorate held a Care Group Centre Board (CGCB), which was attended by senior management and medical staff within the division as well as other key individuals. Subcommittees that reported to the CGCB included a maternity governance group and a gynaecology governance group. The CGCB reported to the Risk Management Executive Committee; a direct subcommittee of the Trust Board.
- The CGCB received reports on human resources and staffing issues as well as performance data for each division. We reviewed the minutes for August and September and noted that discussions around performance were mainly around targets that had been met or general information about what the targets were. There was little discussion recorded about targets that had not been met. We noted that in August a Quality and Safety Report was presented, discussion in the report stated that, “it was highlighted that there appeared to be a lot of red on the dashboard. Target levels and the 0% figures were discussed”. However, there was no record in the minutes about which targets were red or whether they related to maternity or paediatrics.
- The quality dashboard used a RAG (red/amber/green) system of reporting actual performance against the expected. The thresholds for achieving these targets were not clear. For example, for access to maternity services; there was a target of 90% for the percentage of bookings with a gestation of less than 12 weeks 6 days. We saw that achievement for this for one of the months was coloured red and the percentage achievement recorded and for other months was coloured amber. Also, the target for the ‘overall normal birth rate’ was set at 70% for two of the five months reported on; the outcome achieved was less than 70% but was coloured green. This was the same for assisted birth rates. This meant that the data reported in this format could not be relied on.
- The dashboard did not report on maternity readmission rates or unexpected admissions to neonatal unit or unexpected maternal admissions to ITU, 1:1 care in labour or the ratio of midwives to births. It also did not report on the transfer rate of women from MLUs to the consultant-led service. All this information is helpful to review at a glance, to ensure a full perspective of the service is monitored each month.
- It was noted that the patient safety report was discussed at the maternity governance meeting each quarter and that this did include unexpected admissions to NNU.
- The divisional governance committees received regular reports on performance, patient experience, serious incidents, complaints, audits, risk register updates and

infection control, among others, and we saw evidence of this in the minutes. Issues of concern were discussed as were outcomes from audits and other performance data. Actions were agreed and allocated an accountable person to report back to the group.

- A joint maternity and gynaecology feedback group for wider learning was also held every four weeks. Band seven nurses/midwives fed into the governance groups. Each ward/department had their own individual team meeting each month.
- Each division maintained their own risk register and there was a strategy in place outlining how this should be updated and monitored. We reviewed the risk registers and saw that they had a clearly defined title, description and owner, each risk had been scored and existing controls recorded along with any action required. We saw that risks were responded to appropriately.
- The staff we spoke with told us that there were monthly team meetings that they could attend and these included a discussion around general issues affecting their ward. However, most of the staff we spoke with were unaware of how their department was performing against key targets and they told us that they did not receive feedback on lessons learned from incidents unless they had been directly involved.

Leadership of service

- The department had a clearly defined accountability structure. The Care Group Director (also the Head of Midwifery) had responsibility for overseeing midwifery and nursing staff, the Deputy Head of Midwifery and Care Group Lead Nurse, Business Manager and Fertility Manager all reported directly to the Care Group Director. It was noted reporting lines below this were not documented, although staff were aware of their immediate reporting lines.
- The Care Group Medical Director was directly accountable for the Clinical Directors for gynaecology and maternity. As above, staff were aware of reporting lines below this, but these had not been documented.
- Staff all reported that they felt very supported by their immediate line management and that they had good working relationships with all staffing groups.
- The staff we spoke with told us they felt confident in following the trust's whistleblowing policy if they needed to.

Public and staff engagement

- The Women and Children's Care Group had recently implemented a patient experience and engagement strategy in September 2014. The strategy had been shaped by various mediums including complaints, focus groups, surveys and incidents, for example.
- We saw that the Care Group had arrangements in place for patients to complete the Friends and Family Test, although the response rate was below the trust's target.
- The annual staff survey reported that staff were dissatisfied with the level of communication between senior management and staff and that they did not perceive incident reporting as fair and effective.

Services for children and young people

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

Information about the service

Royal Shrewsbury Hospital did not have an inpatient service for children and young people. There was a children and young person's outpatient clinic area and an eight-bedded children's assessment unit (CAU).

There had been a recent review of the provision of children's service. The review had been undertaken to ensure that the needs of the local population were met in a safe and responsive way. The inpatient children's services at Royal Shrewsbury Hospital had moved to Princess Royal Hospital and children were cared for on the CAU, also called Ward 21. The CAU provided services such as GP referrals, blood tests, observations and certain investigations. This change had occurred on 30 September 2014, two weeks before our inspection of the trust.

We visited the CAU and the outpatient area. We spoke with nine members of staff, including both medical and nursing staff, two parents and two children/young people. We observed interactions between patients and staff, considered the environment and looked at two care records.

Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Services for children and young people were found to be good. Children received good care from dedicated, caring and well-trained staff who were skilled in working and communicating with children, young people and their families.

The trust had robust arrangements in place to monitor incidents and staff were clear on their responsibilities relating to this. Children who were seriously ill were appropriately escalated for specialised care and this might involve transfer to Princess Royal Hospital at Telford.

Staff were up to date with mandatory training and robust governance arrangements were in place for children and young people's services and staff were clear on their roles and responsibilities. Staff felt valued and had clear lines of communication through the trust. Staff felt confident in raising concerns and felt listened to regarding ideas to improve services

Services for children and young people

Are services for children and young people safe?

Good

There were effective procedures to support children and young people to have safe care.

Ward areas and equipment were clean. Equipment was well maintained and medicines were appropriately managed.

This was a consultant-led service and there were enough trained staff on duty to ensure that safe care would be delivered.

Children who required specialist care were appropriately identified and transferred and babies were appropriately transferred to the children's unit at Princess Royal Hospital at Telford.

Incidents

- The hospital had systems in place to make sure incidents were reported and investigated appropriately. We saw from data provided by the trust that there had been 79 incidents reported for the period April to June 2014 and that there had been no serious incidents reported in this quarter.
- Staff were able to tell us about how they reported incidents and said that they would have no hesitation in doing so. We saw examples of where incidents had been reported, a full investigation was carried out, including looking at the root cause of why the incident happened in the first place. We also saw evidence that systems were put in place across the women and children's service to prevent the incident happening again. We were shown a root cause analysis investigation and found it to be comprehensive and included areas of notable practice and an action plan for the required improvements.
- There was evidence, in staff meeting minutes, of incident reports being shared. These meetings occurred at monthly intervals.
- The women and children's care group had recently implemented a newsletter to support the sharing of information more widely. The newsletter's purpose was to inform staff of what is going on in the service. For example, some of the key areas of information shared included incidents, risk register and audit. Two members of staff spoken with told us they found the newsletter useful because it also updated them on matters relating to the children's service at Princess Royal Hospital.

Cleanliness, infection control and hygiene

- The areas we visited were clean. Hand-washing facilities were readily available and we observed staff adhering to the trust's 'bare below the elbow' policy.
- Equipment was regularly cleaned and labelled as clean and ready for use.
- We saw evidence that the ward staff had previously had regular feedback, relating to infection prevention and control, at the senior nurses meeting. We were told that this would continue in the new CAU.

Environment and equipment

- The entrance to the children's areas was secure with access by swipe card, or entry granted by a member of staff. All staff wore appropriate identification.
- The unit had resuscitation equipment appropriate for children and young people. We observed that this equipment was checked daily and that this checking was consistently carried out.
- Systems were in place to remove broken or faulty equipment. Staff told us that equipment would be removed from service as soon as a problem was identified and the equipment reviewed by the medical engineers. We saw evidence that maintenance issues were documented and any updates were recorded. Equipment was serviced according to manufacturers' instructions.

Medicines

- Medicines were stored in locked cupboards in a room with secure key-coded entry.
- The stock was in date and the medication reviewed was of the correct strength for children.
- The emergency medications trolley was very comprehensively stocked. We were told emergency medication was rarely used; however the trolley was unlocked and staff checked the contents daily.
- There were no controlled drugs in the CAU at the time of our visit.

Services for children and young people

Records

- Medical and nursing records were stored securely at the nurse's station. Nursing monitoring charts such as fluid charts and observation charts were kept at the end of each child's bed.
- We looked at two sets of care records. We saw clear, detailed notes that reflected each child's care and treatment. Entries were signed and dated in accordance with trust record-keeping policy.

Safeguarding

- The director of nursing led safeguarding arrangements for the trust. The trust had clear governance and quarterly reporting arrangements in place for safeguarding that included both children's and adult's services.
- The trust had a dedicated safeguarding team, which included clinical nursing staff. The team were able to support staff across both hospital sites, keep them informed on safeguarding issues, provide training across the trust and to link directly to other areas of the trust where children are seen, for example A&E departments.
- The safeguarding team trained individual ward nurses to be safeguarding link nurses within their own clinical area. These link nurses acted as an additional resource for their colleagues and were able to assist with training.
- Procedures were in place to obtain the advice and support of a community paediatrician 24 hours a day, which was in line with best practice. When necessary child protection medicals were held in dedicated clinics and by staff who were specially trained to perform them.
- The electronic patient administration system had the facility for alerts to be displayed for any child where safeguarding concerns were already known. The named nurse for safeguarding children told us that the local authority would notify the trust when/if information needed to be updated.
- Medical and nursing staff were trained to level three in children's safeguarding. An up-to-date training registered was held by the safeguarding team. We saw evidence to show that 96% of staff had completed this training and it was up to date. Those staff who had yet to complete it or where it required updating had dates scheduled for their training.
- A safeguarding policy was in place across the trust. We saw that the trust's staff intranet page had a dedicated page relating to safeguarding, which included useful links for staff to access, for example, policies, emergency contact numbers and referral forms. The staff we spoke with all knew how to access the policy, were able to explain the different types of abuse and how they would refer a child if they had any safeguarding concerns.

Mandatory training

- We looked at the training records for the CAU and they showed that all staff were either up to date with their training or had training days scheduled.
- The staff we spoke with all confirmed that they were up to date with their mandatory training. They told us that they received two days training every year that covers all aspects of their statutory and mandatory training. They also told us that they were fully supported by their manager to attend any relevant training.

Management of deteriorating patients

- The paediatric early warning system (PEWS) was used to monitor children and ensure early detection of any deterioration. Care was given by consultants at all times and children considered to be high risk were transferred to Princess Royal Hospital at Telford for further care.
- Nursing and medical staff met daily to undertake a safety briefing to ensure that identifiable risks were recognised and managed (for example, children with the same name).
- Staff were aware of the need to transfer children to another facility if they required inpatient care. There was a clear escalation and transfer policy that staff were well informed about.
- Babies requiring intensive or high-dependency neonatal care were transferred to the trust's sister hospital by ambulance.

Nursing staffing

- The safe staffing dashboard was displayed in the CAU. This showed details of the required levels of staffing and actual levels present on each shift. There was an escalation procedure to follow if required levels were not being met. Staffing levels were adequate and had the required skill mix.
- An acuity tool was used across the trust that used clear descriptions of a child's care needs and the corresponding level of staffing required to provide for those needs. The acuity score was also linked to the paediatric early warning scores.
- Staff in these units were all part of the same rota and children were cared for by staff with a recognised children's nursing qualification.

Services for children and young people

Medical staffing

- There were 20 consultants working across the trust, each with several lead responsibilities. An Associate Specialist was in the Children's Assessment Unit from 9am to 10pm every weekday and 12 noon to 10pm at weekends. A consultant was also on-call at that time and on call for 24 hours
- The Children's Assessment Unit also had access to four nurse practitioners.
- There were no trainee doctors in children's assessment services at Royal Shrewsbury Hospital.

Major incident awareness and training

- All the staff we spoke were aware of the major incident and business continuity policy and understood their roles and responsibilities within a major incident.
- We saw a copy of the trust's major incident policy. The action plans were specific to different roles and level of responsibility and identified the person responsible for leading and coordinating the responses to a major incident.

Are services for children and young people effective?

Good

Children were treated according to national guidance. The services had an annual clinical audit programme to monitor that guidelines were being adhered to. The service audited their performance against national guidelines and protocols for common conditions were up to date.

Children were cared for by a multidisciplinary team of skilled and dedicated staff.

Consultant presence and support was provided over seven days.

Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from NICE and the Royal College of Paediatrics and Child Health.
- Policies, procedures and guidelines were available to all staff through the trust intranet. Staff we spoke with knew how to access them when necessary and quickly found a random number of policies we asked to look at.

Pain relief

- We did not observe any children who required pain relief during our visit. Staff told us that pain control included age-appropriate methods.
- The trust did not have a dedicated paediatric pain management team. We were told by staff that a general pain management team, which covered both adults and children, was based at Princess Royal Hospital at Telford and would provide support when necessary.

Consent

- Parents were involved in giving consent for examinations, as were children when they were old enough to have a level of understanding.
- We observed how staff talked and explained procedures to a child in a way they could understand without being frightened. Staff were aware of Gillick competencies and Fraser guidelines in relation to consent for young people younger than 16 years and followed these when necessary.

Patient outcomes

- The CAU had only been operating in its current form for two weeks at the time of our inspection visit. We saw from previous data that the hospital had an established audit programme of children's and young people's care. These were monitored through dashboard and governance arrangements. Twenty audits were registered for 2014/15 for these services, with a further ten audits awaiting sign-off.

Competent staff

- A change had been made in the way the unit was staffed. The service had been changed to a consultant-led and managed unit, with specialist knowledge and expertise within the team.
- Four nurses had completed advanced practitioner training and all nurses had advanced paediatric life support training.
- Nursing staff at all levels told us about the supervision arrangements in the CAU. They told us that they worked at both Royal Shrewsbury Hospital and Princess Royal Hospital, where the main children's unit was located. All the staff we spoke with told us how well supported they felt by their ward teams, their managers and the senior nursing and managerial staff within the children's service. Senior staff were always on hand to supervise, guide and support junior staff.

Services for children and young people

- Staff told us that training was available and that they were encouraged to develop their skills. They confirmed they had an annual appraisal and their training needs were discussed at this time.

Multidisciplinary working

- There was good multidisciplinary working with physiotherapists, paediatric dieticians and the diabetes team. There was a team of specialist nurses to support children with diabetes.
- The trust had access to the support of a community specialist paediatric psychologist, if necessary.
- GPs had access to consultant paediatricians for advice and support.
- There were strong external links with a number of local authorities, including in Wales, and regular contact with safeguarding leads and social workers.

Seven-day services

- The hospital did not have a children's inpatient service. The CAU was open from 9am to 10 pm every weekday night and 12 noon to 10pm at weekends. Care was led by consultant staff.
- Outpatient clinics were held Monday to Friday.
- There was consultant presence 24 hours a day in the A&E department.
- We were told that pharmacy support and advice was available. The service had a paediatric pharmacist based in Princess Royal Hospital in Telford.

Access to information

- Information on specific health topics and information on how to access hospital services were available for people to access.
- The CAU and outpatient areas had trust policies and procedures available that were accessible to staff on the trust's intranet.

Are services for children and young people caring?

Good

Medical and nursing staff were caring, calm and kind when delivering care and interacting with patients and families. They were described as "very caring and friendly" by patients.

Staff involved children and their parents or carers in decisions about their care and treatment, and they were supported and reassured if they were worried.

Compassionate care

- Throughout our inspection we saw staff interacting positively and in a friendly manner with patients and families, in person and in telephone interactions.
- Feedback from a parent and a young child was positive. A parent told us the CAU was "an excellent facility".
- Reception staff in the outpatients department were friendly and processed appointments quickly and efficiently.
- A mother told us two of her children had attended the hospital on different occasions. She said that local anaesthetic cream had always been used before blood was taken and we observed that when blood tests took place they were done sensitively.

Patient understanding and involvement

- Parents who spoke with us said that they had been involved in discussions about the needs of their child. They felt they had been suitably informed about investigations by staff in the children's outpatients department as well as the CAU.

Emotional support

- The clinical lead for children's services told us referrals for assessments for anxiety and depression were made to the clinical psychologist, based in the community.
- Paediatric specialist nurses such as diabetic, epilepsy and child protection nurses were available for parents and staff to access for support and advice if needed.

Are services for children and young people responsive?

Good

There had been a review of children's services that had resulted in changes to ensure that they were safe and responsive to the needs of children and young people and their families, and clinically sustainable.

Information from the trust demonstrated that the service responded to children and young people about individual complaints or concerns.

Services for children and young people

Service planning and delivery to meet the needs of local people

- On 30 September 2014, changes to the service provided at Royal Shrewsbury Hospital were implemented after a review into the future of women's and children's services. Inpatient services were removed. A children's assessment unit (CAU) was introduced and opened seven days a week from 8am to 10pm on weekdays and 12 noon to 10pm at weekends. Children's outpatient clinics continued and are based in the maternity unit.
- The CAU was not a walk-in service and was accessed only through referrals. They received referrals from GPs as well as internal requests for follow-ups and investigations.
- The trust had also funded the training or employment of advanced paediatric nurse practitioners with specialist training to enable them to assess, manage and provide treatment, including prescribing for a wide range of common self-limiting paediatric illnesses.
- Children who visited the hospital who then required an inpatient bed would be transferred to Princess Royal Hospital.
- Royal Shrewsbury Hospital had a midwife-led maternity unit. Babies born requiring higher levels of support were transferred to the women and children's unit at Princess Royal Hospital by ambulance for more intensive or high-dependency neonatal care.
- The CAU had escalation plans in place to meet capacity and demand for their services.

Access and flow

- At the time of our inspection visit the unit had only been open two weeks. We were therefore unable to ascertain how many children were seen on the unit.
- The records we looked at during our visit showed that the admission and discharge paperwork and checklists had been completed appropriately.
- The children's outpatients unit told us that there was no waiting list to see paediatric consultants and all children were seen quickly after their initial referral, but comparative data was not available.
- We were told that if the child was not fit for discharge, by early evening arrangements were made to transfer them to Princess Royal Hospital. Discussions with staff indicated that there had been no delays in transfers during the first two weeks the unit had been operating.

Meeting people's individual needs

- The environment had been recently refurbished and was clean and bright. Staff told us they had only recently moved into the unit, which was previously an adult ward, and were in the process of making it brighter. For example, at present the walls were a neutral cream colour; staff said they were waiting for permission to make the unit brighter with appropriate bright posters and pictures to create a welcoming child-friendly environment.
- A parent told us that they had received sufficient written information about the tests for which their child was scheduled.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff told us that they would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- Complaints leaflets were available at the entrance to the hospital and outside the CAU.
- The CAU had been open for two weeks at the time of our inspection and had not received any complaints. We saw from data that the children's service had received 20 complaints in 2013/14. A staff member told us that all staff were reminded of the importance of good communication with children and their families in order to address any concerns that were raised. We saw from the newsletter circulated to staff that only three complaints had been received in the first quarter of 2014.

Are services for children and young people well-led?

Good

Services for children and young people were well-led.

Staff told us the service was well-led and there was a flat hierarchical structure. Staff were positive about the service and quality was seen as everyone's responsibility. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements.

Services for children and young people

Risks were appropriately managed and governance systems were being developed to learn effectively from incidents, complaints and audit.

Vision and strategy for this service

- Discussion with the medical and nursing staff at all levels established that there was clear, effective and consistent communication between staff.
- Staff we spoke with were aware of the trust's vision and values. Staff were aware of the financial position of the trust; they believed that children and young people were very well cared for.
- We saw through minutes of meetings, newsletters and staff we spoke with that they had been consulted regarding service developments and design plans such as the move to the new Shropshire Women's and Children's Service at Princess Royal Hospital in Telford.

Governance, risk management and quality measurement

- There was a governance lead for the women and children's services, and governance and risk management were being developed within the new service.
- Key points from the paediatric clinical governance meetings were cascaded to staff in a governance newsletter. Staff confirmed they received the newsletter and we saw a copy in the staff room on the CAU.
- The risk register was up to date and there were no entries on the divisional risk register relating to the reconfigured children's services at Royal Shrewsbury Hospital.

Leadership of service

- Children's services were part of the Women and Children's Care Group. All staff spoken with were aware of the management structure beyond their unit. Both nurses and doctors told us senior management, including the director of nursing and medical director, were very visible to staff.
- Staff spoke highly of their ward managers and had confidence in their leadership.
- The ward manager we spoke with also said they felt supported by senior management and that if they raised any concerns about the service they would be listened to.

Culture within the service

- The staff described an open culture where they were encouraged to report incidents, concerns and complaints with their manager. Staff felt able to raise any concerns.
- We saw a copy of the Women and Children's staff newsletter, which detailed that complaints and serious incidents were discussed to enable learning between and within teams. Staff told us that incidents were shared across the trust.

Public and staff engagement

- Staff told us of good engagement in the service. They had been kept informed of service changes. They were able to continue to work for the trust and had been able to transfer to Princess Royal Hospital when children's inpatient services were removed from Shrewsbury.
- Focus and public meetings had been held for patients and families.
- A parent spoken with told us that people had been consulted about the proposed changes to women and children's services at the hospital. They said that the public had been invited to view the CAU at an open day before it opened and that a mailshot detailing the facility had been sent to every household in Shrewsbury.
- A patient experience survey for March 2014 showed that 100% of paediatric patients felt they had been treated with dignity and respect and 88% of patients felt they had been treated with kindness and compassion.

Innovation, improvement and sustainability

- The clinical director told us how the service was developing by creating new links in the community and with GPs, with the aim of ensuring that the services provided would best meet the needs of the local population.
- The trust plans to develop a new children's outpatients centre. No date had been set for this, but some staff in the outpatients department told us they understood this would happen before the end of 2014.

End of life care

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

Information about the service

End of life care/palliative care services are provided throughout the Shrewsbury and Telford Hospital NHS Trust and at Royal Shrewsbury Hospital and Princess Royal Hospital.

The trust's palliative care team and end of life care team provided a five-day service and were available 9am to 5pm Monday to Friday for both hospital sites. Weekend support was available through an on-call service from the nearby hospice. The team was made up of four nurses. These nurses were funded partly by the local hospice service. The trust had recently appointed an end of life care coordinator to improve the provision of end of life care. There were no palliative care doctors on staff employed by the trust; palliative support was provided by the hospice on a weekly basis. The trust had a part-time doctor who led on end of life care, but this was a voluntary role and not part of their current contract.

Three of the palliative care nurses were based at Royal Shrewsbury Hospital. Inpatients who require palliative or end of life care were nursed on the wards throughout the hospital. Specific end of life care was provided for patients with renal illnesses, both acute and chronic, through the inpatient ward and the renal dialysis unit.

Royal Shrewsbury Hospital had a chaplaincy service available as well as access to local support and counselling services. There was a chapel on-site where people could go to pray. There was a bereavement team on-site, but the majority of bereavement work was undertaken through the ward where the person died. The mortuary facilitated viewings for families who were bereaved. The facilities for the viewing of children and babies have recently transferred to the mortuary at Princess Royal Hospital in Telford, together with the new women's and children's unit.

Before this inspection we were informed by the trust that they had recognised that end of life care was not being delivered to a standard that they expected and that it required improvement.

End of life care

Summary of findings

End of life care required improvements in all areas except for safety, which was inadequate, and caring, which was good. The service was not safe because the mortuary environment and equipment within the mortuary were inadequately maintained. The environment was old and the fridges where deceased patients were kept regularly malfunctioned, which could affect the preservation of the bodies. The storage capacity within the service was also insufficient to cope with increased demand.

End of life services required improvement in effectiveness because the trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. The trust did partake in the National Care of the Dying Audit 2014 and performed worse than the England average on five out of seven organisational indicators and all clinical key performance indicators.

The service was not responsive because there was no formal strategic plan for the delivery of end of life care within the trust. There were also no designated beds for providing patients with palliative care. The viewing room for children in the mortuary was not responsive. The room was small and not welcoming and to view children in this room could be considered uncaring towards bereaved families. The layout of the renal dialysis unit was not responsive. Patients coming in for their daily treatment had to walk through the acute inpatient area.

The service was not well led. On an individual level people were well cared for and locally those providing end of life care within departments led the provision of this well. However, we found that there was oversight by senior management and members of the executive team with regards to end of life care that required improvement.

Staffing levels of nurses and medical staff in palliative care were not sufficient to reach all patients who may have benefitted from their expertise. Staff were not provided with mandatory training in end of life care.

Are end of life care services safe?

Inadequate

We found that the mortuary environment and equipment within the mortuary was inadequately maintained. The environment was old and the fridges where deceased patients were kept regularly malfunctioned, which could affect the preservation of the bodies. The storage capacity within the service was also insufficient to cope with increased demand.

Staffing levels of nurses and medical staff in palliative care were not sufficient to ensure that end of life care was delivered safely. The staff currently working for palliative care were either partially funded by another service or providing their time voluntarily. The trust has not sufficiently invested in end of life care to make it a service.

Staff were not provided with mandatory training in end of life care. Staff who have attended this training have usually financed it themselves There were no incidents that related directly to end of life care that had been reported. Staff knew how to report incidents. We saw good hand hygiene practice by staff when they were caring for patients.

The trust had recently re-issued 'do not attempt cardiopulmonary resuscitation' records and renamed the process the 'ceiling of treatment to allow a natural death'. This was done two weeks before our inspection. We found all forms had been completed in line with guidelines, but the effectiveness of this process had yet to be tested through clinical audit.

Incidents

- Staff told us they were encouraged to report incidents but could not recall any specific incidents relating to end of life care. This is not uncommon because many incidents relating to the death of a patient are reported under the specialty where the death occurred.

Cleanliness, infection control and hygiene

- In the mortuary we found that appropriate guidance was followed for maintaining a clean environment and reducing the risk of infection. The mortuary team worked hard to maintain a clean environment given the physical condition of the existing mortuary, which had not been upgraded or refurbished for many years.

End of life care

- The temporary mortuary store was not visibly clean when we viewed it, we observed stains on the walls on the inside of the room. The mortuary staff were unable to remove these stains.
- We observed that the mortuary adopted appropriate protocols for high-risk post-mortems by restricting access and securing the room while the procedure took place. This minimised the potential spread of any infectious disease.

Environment and equipment

- We checked a range of equipment including syringe drivers and monitoring devices and found all had been serviced and tested for electrical safety.
- The hospital had syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication. Syringe drivers in use were standardised to one type of equipment that could minimise the risk of human or training error. However, when we examined the equipment asset register we found that some items did not have a specified date to show it had been recently tested. Not regularly testing the function of a syringe driver may place people at risk if the equipment malfunctions.
- The mortuary environment had not been upgraded or refurbished since the trust took ownership of the site. While minor remedial work had been undertaken, the environment had been neglected through a lack of investment by the trust, leading to major safety concerns.
- In September 2014 the trust approved a refurbishment plan of £1.4 million to improve the mortuary environment.
- The mortuary refrigeration area was installed in the 1970s and is becoming increasingly unreliable. Even when the units are working, they are unable to maintain the required temperature, which could result in accelerated decomposition of the deceased. The two fridges within the mortuary had broken down on at least two occasions during the 2014 summer months.
- Service reports seen show that the fridges were condemned for use five years ago, but have yet to be replaced.
- The fridges are cased in asbestos cement. The trust has risk assessed and ensured the asbestos is contained safely to minimise risk of exposure to staff.
- The entrance way for visitors is a Portakabin; the entrance area flooring had recently collapsed and had been temporarily covered with plywood flooring. Therefore we were not assured that the environment had been safely maintained for public use.
- The temporary mortuary store near the main entrance had a history of reported temperature control concerns, with the temperature often being above the recommended 4°C, which increases the risk of decomposition and exposing patients to risk of infection.
- The fridges could not accommodate deceased bariatric patients because the spaces within the refrigerators are too small. Because of the age of the units, the refrigerators could not be modified.
- The temporary store is accessed by a ramp and is not suitable for bariatric storage. If a bariatric patient body needs to be stored, the only option available in the mortuary is to use the paediatric viewing room, which can accommodate one patient. In the event of two bariatric deaths, one of the bodies would have to be stored in an unrefrigerated area.

Medicines

- Staff told us patients who required end of life care medicines were written up for anticipatory medicines. We examined the records of two patients receiving end of life care and found that anticipatory medication was appropriately prescribed.
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. This is medication that patients may need to make them more comfortable.

Records

- We examined the records of 8 patients receiving end of life care or with an advanced decision for end of life care in place. Records were comprehensive around the decision for end of life care. This included detailed recording of conversations between health professionals and with family members and patients during visiting times. We spoke with two family members and one patient about their conversations. We found that people's accounts of conversations matched what was recorded in their records.
- We reviewed 8 patient medical records containing 'do not attempt cardiopulmonary resuscitation' forms. The

trust had recently revised these forms and it is now referred to as a 'ceiling of treatment to allow a natural death' form. We found all forms had been completed in line with Resuscitation Council (UK) guidelines.

- We found that once a decision of end of life had been made, there was no evidence recorded to review the decision. This meant that the decision may not be being reviewed as required in line with Resuscitation Council (UK) guidelines and Article 8 of the European Convention of Human Rights.
- Written records were legible and clear to read. However, some doctors did not always write their General Medical Council number on the recorded entries.
- We reviewed the documentation for certification after a patient died. A medical certificate of cause of death enables the deceased's family to register the death. We found the certificates had been issued within 14 days of death, and burial or cremation forms had been signed in accordance with the Births and Deaths Registration Act 1953.
- When there had been any doubt as to the cause of death or the cause of death required a mandatory referral, for example when a death may be linked to an accident (wherever it occurred) or industrial disease, we found that the hospital appropriately referred cases to Her Majesty's Coroner.
- We found that there were robust consent arrangements in place for managing tissue removal after death. The last Human Tissue Authority (HTA) inspection raised concerns related to environment but found no concerns with the records maintained. The HTA regulate organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public.

Safeguarding

- We examined the training records for the palliative care team and found that 100% of the staff had received training in safeguarding adults and safeguarding children. Across the medical areas we established that between 70% and 100% of staff in medical areas had received this training.
- Staff across the medical areas we visited were able to explain what constituted a safeguarding concern and the steps required to report such concerns.

Mandatory training

- The palliative care team and mortuary team had access to all training sessions provided by the trust. The mandatory training matrix provided by the trust showed that the palliative care team had achieved 100% compliance with training in subjects including infection control, health and safety and moving and handling.
- End of life care training was not classified as mandatory training and was not routinely offered to staff. Therefore staff were not up to date with requirements for end of life care of patients.

Nursing staffing

- There were four palliative care nurses employed by the trust, three of whom mainly worked at the Royal Shrewsbury Hospital site. Two of these nurses are 50% funded by the local hospice.
- The trust had recently employed an end of life care coordinator to support the delivery of end of life care. This post is funded for two years by Health Education England and not by the trust.
- On the renal unit the service had a transplant sister in post. This post supported patients with cross-matching for transplantations and was funded by the British Kidney Association and not by the trust. The HR processes internally had decided not to fund this post at the end of the charitable funding period from December 2014 for financial reasons. However, since the inspection we have been informed that this decision is subject to review.

Medical staffing

- There were no palliative care doctors employed by the trust to support the provision of end of palliative care. The trust has an informal arrangement and a good working relationship with the local hospice to provide consultant support when required.
- The trust has an end of life care doctor who works part time as a medical physician. The doctor chose to lead the subject of end of life care to improve services. The role is not part of their contract and the hours given to this work are voluntary.

Major incident awareness and training

- The mortuary staff had received training in emergency planning and resilience. The service had a current major incident plan and were aware of what procedures to follow in the event of a major incident.

End of life care

- The maximum body storage capacity in the mortuary 54 (including temporary storage). While this capacity is usually sufficient during the summer months when the death rate is generally lower, it is insufficient during the winter months, when the death rate is higher.
- There is a standard operating procedure in place for the management of the deceased when demand for spaces exceeds those available. This has consistently been reported as an issue during the winter for several years. The trust has reported near miss incidents of having to store the deceased in a manner that is not approved by the Human Tissue Authority.
- The current capacity offers no resilience for unexpected surge in demand, for example a pandemic flu or Ebola outbreak. Therefore the capacity issues within the mortuary means that the service would have difficulty in coping with a moderate increase in deceased patients in the event of a major incident.

Are end of life care services effective?

Inadequate

The trust participated in the National Care of the Dying Audit 2014 and performed worse than the England average on five out of seven of the operational and all clinical key performance indicators. Local audits around end of life care were limited and still being developed.

The trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. This tool was a care plan developed by medical and nursing staff to replace the Liverpool Care Pathway. The trust planned to roll this out once staff had been trained to use the tool appropriately.

We found that many of the services that supported end of life care to patients were working under considerable pressure, due to workload. Staff working on the wards felt able to contact the palliative care team for advice, but this service only operated during weekdays within office hours. This meant that people risked receiving a different level of service outside normal office hours. However, we found that staff involved in end of life care often worked extra hours, on a goodwill basis, to provide out-of-hours and weekend cover to support the delivery of care seven days a week.

We reviewed 'ceiling of treatment to allow a natural death' forms to determine if mental capacity had been assessed. In four cases the form had been completed stating that the patient did not have mental capacity, however there was no record of mental capacity assessments being undertaken.

Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available. Medical staff were aware of the General Medical Council's requirements for nutrition and hydration at the end of a person's life. However the clinical decision model for adult patients who lack mental capacity was not always being followed. Input from dieticians and the speech and language therapy service was available.

Evidence-based care and treatment

- The trust adheres to NICE's End of Life Care Quality Standard (QS13 August 2011). We viewed the trust's board papers through 2014 and plans that demonstrated that the trust had considered and agreed how to improve the service.
- The Department of Health asked all acute hospital trusts to undertake an immediate clinical review of patients receiving end of life care. This was in response to the national independent review, More Care, Less Pathway: A Review of the Liverpool Care Pathway, published in 2013. The service had only recently removed the Liverpool Care Pathway from use. This has been replaced with an 'End of Life care' pathway, which is yet to be implemented.
- A new end of life care pathway plan, to replace the Liverpool Care Pathway (LCP) had yet to be launched within the trust. The director of nursing informed us that the trust did not want to implement a new plan unless it was used appropriately; the plan will be used when staff are trained and skilled in its use.
- The pathway had been developed across all health services within Shropshire. The end of life lead doctor and director of nursing referred to this as 'care without walls'. This document developed, by the trust, had been agreed throughout the community to ensure that patients have one care plan that ensures continuity in care. There was an action plan linked to the implementation of the new end of life care plan.
- The palliative care team were aware of the change and the end of life care coordinator was leading the implementation of the new plan. Staff were

knowledgeable about what a patient required at the end of their life and we observed that they followed the principles of the plan, which was not yet in use, to provide appropriate care.

Pain relief

- Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available.

Nutrition and hydration

- There was no specific dietician support for the palliative care team and this meant that end of life nutritional support was provided by dieticians across the trust.
- However, we saw input from dieticians in the medical notes of patients. Nursing staff on the ward told us they could always ask for dietetics advice.
- The trust had a speech and language therapy service that provided support for nutritional and hydration needs, when required. We observed an example of this being provided to a patient receiving end of life care.
- We spoke with three doctors across the medical wards we visited. All were aware of the General Medical Council's requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the consent systems appropriately when patients did not have capacity to consent to care and treatment. The record of consent was documented in the care records.
- We examined the records of eight patients with 'ceiling of treatment to allow a natural death' forms to determine if their mental capacity had been assessed before completing the decision not to attempt cardio-pulmonary resuscitation. In four cases the form had been completed stating that the patient did not have mental capacity, however there was no record of mental capacity assessments being undertaken. Therefore medical staff may not be following the Mental Capacity Act 2005 in relation to making best interest decisions for end of life care.
- We reviewed the Advanced Decisions (living wills) policy issued in November 2012. Section 6.7 of the policy states 'patients cannot refuse basic care'. This is not in accordance with a person's human rights or the Mental Capacity Act 2005 because a person can refuse basic care if they have the mental capacity and ability to do so.

Patient outcomes

- The trust had taken part in the National Care of the Dying Audit 2014. Of the seven key performance organisational indicators, the trust achieved below average on five indicators but did meet the other two indicators. The trust was reportedly promoting the privacy and dignity of the patient up to and after the time of death, obtaining access to specialist support and prescribing required medicines.
- Of the 10 clinical key performance indicators, the trust did not achieve any of the required recommendations. This included communication regarding a patient's plan of care when dying and assessment of the patient and families' spiritual needs.
- Locally we found that the service had undertaken an audit on the completion of 'do not attempt cardiopulmonary resuscitation'. The audit showed that appropriate discussions were not always being undertaken with patients and their families. The trust has re-launched the process of 'do not attempt cardiopulmonary resuscitation' and renamed it the 'ceiling of treatment to allow a natural death'.
- The trust has yet to re-audit the implementation of this new process to determine how effective it has been. The re-audit is scheduled to be undertaken after three months of the process being in use. Clinical sessions for the medical staff to improve their skills around having difficult conversations with families are also scheduled to take place.

Competent staff

- We found that end of life care training, dignity in death or palliative care training was not a mandatory training subject for staff at the trust. We found a number of instances where staff who had undertaken training on these subjects had done this in their own time and in some cases through their own funding.
- During the inspection we found that the renal ward and renal dialysis unit had nominated a link staff nurse and a doctor to support the improvement of end of life care. These roles were voluntary and in addition to their current job roles.

End of life care

- The palliative care team, pain management team and mortuary staff had all had appraisals within the past year.

Multidisciplinary working

- The hospital has a palliative care team who are part funded by the local hospice. The trust does not have a palliative care doctor, but one is available from the hospice on request. While there was no formal service level agreement in place to establish how many hours per week they provide to support the trust, we were informed by all areas they could access this support when required.
- Within the renal unit the end of life doctor and link nurse provided hours to support the delivery of end of life care. The transplant sister and newly appointed psychologist were all funded through external bodies. The team provided guidance on making decisions about end of life care and treatment options, and gave specialist holistic advice and support for patients and their relatives.
- The palliative care team members attended regular multidisciplinary team meetings for specialist teams, such as cancer, renal and respiratory services. The end of life care doctor also attended some of these meetings as part of the clinical specialty and could strongly advocate end of life care needs.
- Patients under specialist teams did benefit from the palliative care and end of life team involvement. While care, treatment and support was delivered to meet the patients' individual needs, this was predominantly through the good will and dedication of staff as well as external funding to support posts delivering end of life care.
- The multidisciplinary team worked well together to ensure that patients' care and treatment were planned and coordinated. We spoke with two families who were positive about the care they received and the support they were given.
- There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place to die. Equally if a person preferred to die at home, arrangements could be made to facilitate this. The use of the palliative care team ensured continuity of care when working with community teams.

Seven-day services

- The palliative care service was only available Monday to Friday within working hours. Out-of-hours support was provided at the weekends from the local hospice, though no formal agreement had been established.
- We found that staff providing care around end of life care, including the end of life care team, palliative care team, link nurses and medical staff with a voluntary role as end of life medical leads, often worked to provide out-of-hours and weekend cover to support the delivery of care seven days a week. This was provided as good will to deliver a service to the patients.

Are end of life care services caring?

Good

Staff at Royal Shrewsbury Hospital provided very compassionate care to patients from the time a terminal diagnosis was given to the time of their death. There was good recognition of the importance of family and friends as life ended.

We observed outstanding examples of end of life care on the renal dialysis unit when supporting patients to make decisions regarding their wishes. Staff shared their recent experiences of patients receiving dialysis and holding birthday parties and Christmas parties to celebrate events. Staff also shared that they were often asked to attend funerals of patients by families. The dedication and passion to provide a caring service was observed throughout the visit. All patients and relatives we spoke with on the renal ward and renal dialysis unit spoke highly about the level of compassion and care displayed by these teams.

Locally in the teams within the wards visited, which included respiratory, care of the elderly, renal and the renal dialysis unit, staff spoke highly of the care offered by the palliative care team and the end of life care link staff, including the lead consultant for end of life care. Many of the roles that support the delivery of end of life or palliative care were developed through staff's passion to deliver good care at the end of a person's life. Staff worked above and beyond the call of duty to try and support patients and their families at difficult times.

Within the mortuary the team worked with a challenging and poorly maintained environment to try and provide a

End of life care

caring service to the families and to the deceased. Staff within the mortuary service demonstrated their passion for making a difficult situation better for those involved and worked to deliver this with the limited resource and options available.

Compassionate care

- Throughout our inspection we witnessed patients with a terminal diagnosis, those approaching or at the end of life being treated with compassion, dignity and respect. We spoke with three patients and two family members during our inspection specifically about their experience of end of life care. All told us that they were cared for exceptionally well.
- Staff on the renal unit provided us with examples of when they had been invited to the funerals and birthday celebrations of patients. Staff were engaged in care at a level that meant that families felt supported by the staff when a patient and family went through difficult times.
- We spoke with three patients on the renal unit and one family; all were highly complimentary about the level of care and compassion that staff within the renal service displayed towards them. Comments included, "I can talk to them, they always listen" and "they cannot do enough for me, they are such wonderful people."
- The chaplain told us that they were able to assist the nursing staff to ensure that care and treatment was provided to patients with due regard to their religion. The wards we visited, which included respiratory, care of the elderly, renal and the renal dialysis unit, told us that they received regular input from the chaplaincy team.

Patient understanding and involvement

- The NHS inpatient survey results showed that the trust was in line with the England average on questions asked about caring and involvement of patients and their families during treatment in hospital.
- The palliative care team worked with the clinical teams to arrange for the patient to die in their preferred place of death where possible. During the inspection we observed a patient's care on the renal ward discussed during a multidisciplinary meeting. Consideration to the patient's preferences on place of death was given.
- In the renal service each patient with end-stage renal disease, which is when the kidneys are no longer able to work at a level needed for day-to-day life, has a named nurse. The named nurses provide a personal relationship with the patient to talk about their condition as it progresses.
- All renal patients receiving end of life care who we spoke with knew who their named nurse was. The two patients who were nearing the end of life knew their palliative care named nurse and their doctors. The relatives of the two patients we spoke with also knew who their relative's named nurse and doctors were.

Emotional support

- Chaplaincy support was available 24 hours a day through an on-call system. The ordained chaplains were supported in their work by chaplaincy volunteers. The chaplaincy service covered the two hospital sites and there were only three chaplains available for on-call. As a result, service availability could impact on patient care.
- The community of Shrewsbury was predominantly Christian. There were multi-faith chaplains available and alternative religious chaplains could be available on request.
- Within the renal dialysis unit the service had recently secured funding from an external source to fund the role of a clinical psychologist to support the emotional needs of patients. This role was seen as a critical support to patients classed as 'end stage' in their treatment.
- Support was available from the mortuary and the bereavement team for people who wished to view deceased relatives. The mortuary staff explained to us how they would support people and make the difficult experience as comfortable as they could and offered support to meet individual patient needs.
- For women who were bereaved following the loss of children, specialist support was available through the bereavement midwife. The maternity and children's service moved to Princess Royal Hospital in Telford two weeks before our visit; however, the bereavement midwife would continue to visit the site to support families of terminated pregnancies and those who had lost babies through any unexpected event.
- Support was also available through the paediatric service for the loss of children. Though most children are now seen at Princess Royal Hospital, the staff informed us that they will maintain this support service across both sites.

Are end of life care services responsive?

End of life care

Requires Improvement

The chapel and the mortuary public areas were designed towards people with a Christian faith and were not responsive to people of other faiths. The viewing room for children in the mortuary was not responsive. The room was small and not welcoming and to view children in this room could be considered uncaring towards bereaved families.

The end of life care and palliative care team supported the provision of rapid discharge and rates of discharge within 24 hours were in line with the England average. For patients who were considered to be nearing the end of their life, the normal visiting times were waived when relatives visited the hospital and discounted parking fees were also available.

Complaints were being recognised and lessons were being learnt from the concerns. Relatives were being invited to share their experience to promote learning and improve the delivery of end of life care.

Service planning and delivery to meet the needs of local people

- Ward staff alerted the palliative care team to patients who required palliative care. The palliative care team prioritised visiting these patients to ensure that they were seen in a timely manner.
- The trust had a policy in place regarding visiting times for visitors in ward and department areas. This policy is usually enforced by the person in charge of the area. We found that for patients who were deemed to be nearing the end of their life, the normal visiting times were waived when relatives visited the hospital and that discounted parking fees were also available.

Access and flow

- Before the inspection we were contacted by two relatives of patients who died about their experiences, where patients were unable to access the rapid discharge process at the weekends during the previous 12 months. We reviewed this process and found that rapid discharge protocols and processes now in place were seen to be effective in getting people to their preferred place of care prior to their death. The palliative care team provided support at the weekends to ensure that patients were able to increasingly chose the place of death throughout the week.
- The pathway is being supported by the end of life care team and delivered with support from the palliative team to improve the care provided to people at their place of death and our observations supported that rapid discharge arrangements were improving.

Meeting people's individual needs

- The chapel was designed predominantly for people of Christian faith with stained glass windows and an alter area. Mats were available for Muslim prayer, though these were out of view. There was limited signage or information to support people of alternative religions to find the available materials needed to support their religious needs.
- Christian bibles and information on faith was available in the chapel in Welsh.
- Translation services were available 24 hours a day through a telephone service.
- On the renal dialysis unit we observed a family member translating messages between staff and their relative who was the patient. We examined the records that demonstrated discussions with the relative and patient without a translator. We spoke with staff who confirmed that the relative often translated to the patient for them. Translation of clinical messages should be done independently because there is a risk of miscommunication by using a relative to communicate messages.
- The entrance area to the mortuary was also the overflow area to store the deceased. There was a weak bad odour in this area and it was clear to all visiting what was contained within the room next to the entrance. The set up and design of this area did not feel welcoming to bereaved families.
- The mortuary viewing room wall had a large wooden cross on the wall. This was placed on a wooden wall and could not be removed. This could potentially have an emotional and psychological effect on people of non-Christian faiths who wished to view their relatives.
- The viewing room for deceased children was an area off a corridor that had two doors either side. The room was small and did not suit the needs of families at a difficult time.
- Staff in the mortuary had made provisions to offer a more personable way of supporting families. This included items such as children's bedding, alternative

blankets and a Moses basket. Though no complaints had been received about the environment, the mortuary staff recognised that the viewing area for children was not fit for purpose.

- The renal dialysis unit offers dialysis to acute and chronic patients. The acute patient area is situated at the front of the unit; all patients have come from the wards and are on beds. The chronic area is situated further back. The layout was not responsive because chronic patients coming in for their treatment had to walk through the acute area. Staff reported that chronic patients had raised concerns about being able to see the acute patients. Staff shared that there are cardiac arrests within the acute area in the department, on average one per month, and this causes psychological distress to the chronic patients who witness them.
- The trust was compiling its data and evidence of patients who are able to die in their preferred location. While no actual figures were available at the time of inspection, the director of nursing recognised that improvements around the delivery of patients' needs was required.
- The discharge team and the palliative care team detailed their processes for discharging patients within 24 hours. The trust was in line with the England average on meeting the rapid discharge requirements.
- There was a selection of patient information materials available to support patients and their families in understanding what to expect at the end of life and when a terminal diagnosis is given. We saw that these were available around the hospital.

Learning from complaints and concerns

- Complaints were being recognised and lessons were being learnt from the concerns. The lead doctor and director of nursing reviewed and responded to every concern about end of life care.
- The trust has received five complaints in the last few months in relation to end of life care. These are complaints where the primary concerns were care at the end of life.
- Patients or relatives who had raised concerns about end of life care were invited in by the director of nursing to attend the trust board meetings to share their experience. We viewed the trust board minutes and identified three examples over the last six months where relatives had attended and shared their experience.

Are end of life care services well-led?

Requires Improvement

There was no formal strategic plan for the service delivery off end of life care at the trust.

Locally those providing end of life care within departments led the provision of this well. The clinical lead demonstrated good leadership and clearly wanted to drive improvement around end of life care.

We found that there was limited oversight by senior management and members of the executive team with regards to end of life care that required improvement, but this was developing as the trust had recently recognised end of life care as a key area for development. The director of nursing was the executive director for end of life care. She was able to demonstrate that she understood the enormity of the improvements required around end of life care.

Vision and strategy for this service

- There was no clear over-arching vision or strategy for the end of life care service. Staff providing end of life care were aware that there were plans being developed to improve the trust's end of life care pathway but were unclear when it would be launched.
- In the different departments and areas we visited, staff demonstrated that they understood what their contribution was to providing care to a person at the end of their life. Each area had its own approach for this. For example, in the mortuary there were clear procedures for end of life care, renal services had developed their own strategy to support end of life needs which was specific to end stage patients.
- The transplant nurse role is within the renal service and supported a vision for the service to improve patient outcomes and the chance to receive a transplant. The funding for the role is scheduled to run out in December 2014. We found that the role had been declined for further funding through the HR vacancy control group and the role will no longer be available, which will have a negative impact on patients in the renal service. At the time of writing this report we have been informed that the decision not to fund the post is subject to review.

End of life care

- The trust does not have a functioning organ transplant meeting. This is an area that has been recognised by the director of nursing as needing to be re-launched.
- The trust had recognised that mortuary services require improvement and funding has been approved to improve the mortuary environment to provide a sustainable service.

Governance, risk management and quality measurement

- The director of nursing and end of life care lead doctor were undertaking the quality measurement of end of life care and recognised what needed improvement. At the time of inspection there was no definitive risk management or quality measurement plan with timeframes for improvement in place.

Leadership of service

- The director of nursing had recently taken up the role of executive lead for end of life care. Before this there had been no executive or non-executive leadership for the service.
- The end of life care doctor also worked as a consultant within medical specialities. The hours provided to end of life care were on a voluntary basis. The lead consultant demonstrated good leadership, passion and dedication to the improvement of end of life care, but their role lacked the required support from the trust.
- At the time of our inspection, there was no non-executive director with responsibility for end of life care. This is a recommendation from Norman Lamb after publication of the review of the Liverpool Care Pathway in his letter to NHS Trust Chairs and Chief Executives in July 2013.
- There was currently no palliative care consultant employed by the trust. The service utilised an informal arrangement with the local hospice, but this was informal and there was no service level agreement in place.
- The team providing end of life care was limited. Of those providing an end of life care service, the trust contributed little to these roles financially. Two of the four palliative care nurses were part funded by the local hospice. The end of life coordinator post was funded by Health Education England and the local hospice. The transplant sister and clinical psychologist in the renal service were funded by the British Kidney Association. The reliance on charitable and voluntary funding means that the provision of support for end of life care for this trust is not sustainable.
- Within the renal service the team had good leadership understanding knowledge with regard to end of life care. The service had internally self-appointed a link nurse lead for end of life care and a renal consultant also took the lead as a named doctor for renal end of life care.

Culture within the service

- We observed examples of staff members who worked as visible and approachable leaders for end of life care. We also observed the example of a staff member who worked below their pay grade and volunteered to work at the lower pay grade to ensure care was delivered to patients. This showed dedication to the delivery of improved patient care, but it did not support staff wellbeing.
- Locally the passion and dedication towards delivering good care at the end of a patient's life was clear to see throughout the inspection. The palliative care and end of life team dedicated a lot of hours to delivering the best service possible within their available resources. However much of this was provided by the goodwill of staff and there was limited input and oversight from the trust executive management and senior management team.

Public and staff engagement

- We were told that staff engagement with end of life care had improved in the months leading up to our inspection. This included inviting relatives of patients in to the trust to share their experience openly to improve the service.
- The service promoted the completion of the National Bereavement Survey and was aiming to improve their response rates from the public.
- Locally staff told us that they felt supported by their immediate managers, but they did not always feel supported by the senior management team. Staff also felt a lack of engagement from the executive team around end of life care.
- Staff shared examples of escalating concerns to senior management and members of the executive team over the past two years, but had received little or no support or response. Examples included the environment and capacity within the mortuary and the specialist staff support in the palliative, end of life and renal services.

End of life care

Innovation, improvement and sustainability

- The new end of life care plan, which has yet to be launched within the trust, has been developed across all health services within Shropshire. The end of life lead doctor and director of nursing referred to this as 'care without walls'. This document developed by the trust has been agreed throughout the community to ensure that patients have one care plan that ensures continuity in care.
- Locally we saw numerous examples of innovative practice, particularly in the renal service with the functions of the transplant sister and the end of life care link nurse. There was also a consistent drive to secure funding from external sources to improve their service for patients.
- On the renal dialysis unit and ward the service secured a two-year funding arrangement for a transplant sister to support renal transplantation. The role supports the cross-matching of patients to receive transplant through live and deceased people. From April 2013 to April 2014 the number of patients who received a transplant increased from 12 to 17. This included six new live donor transplants.
- We found that the team had also established, through promotion of services, another nine people willing to be consulted and matched to provide a kidney as a living transplant organ donor. This work is significantly improving the outcomes for patients receiving dialysis.

Outpatients and diagnostic imaging

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

Information about the service

There were two main outpatient facilities, which were based at Royal Shrewsbury Hospital and Princess Royal Hospital Telford.

The two locations have local management systems that were overseen by senior managers at trust level.

This report concentrates on our findings at Royal Shrewsbury Hospital.

During the period April 2013 to April 2014, Royal Shrewsbury Hospital conducted 277,045 outpatient appointments, of which over 94,000 were first appointments.

On the day of our inspection we were able to visit a number of clinics providing specialist services, including, ophthalmology, orthodontics, gynaecology, maxi facial, vascular, muscular skeletal, audiology and fracture clinics. We also visited x-ray and scanning services and support and administration departments.

We observed how staff interacted with patients, their families and carers.

We spoke with 29 staff working in the clinics and with 22 patients or family members about their care and treatment.

Summary of findings

Overall we rated this service as good. Outpatients and diagnostic imaging services were safe. The trust had prioritised statutory training, but refresher mandatory training had not been completed by the majority of staff. Mandatory training was provided at the trust's discretion and to ensure compliance with local standards and policies. This meant that the trust could not be confident that staff were following the most recent advice and guidance.

We saw good practice and effective, compassionate care. Patients were very complimentary about all the staff they had come into contact with. Staff were observed to be caring and compassionate in the way they dealt with patients and their families or carers. They were knowledgeable and enthusiastic about the service they provided and this was reflected in how they engaged with people.

We saw good practice and some innovative working and interpretation of NICE guidance to the benefit of patients and the trust. Services were managed well at a local level; appraisals and supervision of practice were completed. Meetings took place between staff and managers. Staff felt supported and they told us they respected their managers.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found issues with the level of mandatory training for staff in both outpatients and diagnostic imaging. Staff were able to demonstrate a good understanding of the subjects; all staff had received training previously either on induction or during previous years. However; this did mean that the trust could not be confident that staff were aware of the most recent practice and guidance.

The environment in the records department was not conducive to the safe handling of patient records or the safety and comfort of staff. Flooring in the department posed a safety risk and racks for records were insufficient for the number of files stored there.

Records regularly went missing, issues regarding availability of health records had been placed on the trust risk register for the outpatients department

Recent problems with clinic letters had meant patients were missing appointment but we were reassured this problem had now been addressed.

Staffing levels and skill mix were in line with national guidance. Absences were largely filled from within teams rather than using agency staff, this meant that staff were familiar with the environment and how services were run, providing continuity for patients.

Equipment was maintained to ensure it was available when required and that it operated safely. There was evidence of equipment that was reaching the end of its useful life being replaced.

There were effective systems to safeguard children and vulnerable adults from abuse. Staff understood how to recognise the different forms of abuse and how to make a safeguarding referral if they had concerns.

Incidents

- The trust used the Datix reporting system to record incidents and issues of concern. Staff at all levels of the organisation were aware of how to use the Datix system and many were able to explain when they had used the system to report incidents. Some staff told us that they didn't always receive feedback about incidents, but they described how more serious incidents were responded to, which gave them confidence in the system as a whole. During a focus group with healthcare workers and student nurses, which included staff from a number of areas including outpatients and diagnostic imaging services, they told us they understood Datix and found it easy to use.
- In the period April 2013 to April 2014, the trust reported a total of nine serious incidents in relation to outpatients and diagnostic imaging services. Royal Shrewsbury Hospital accounted for eight of the serious incidents.
- We saw that incidents had been investigated and root cause analysis had been completed to identify causes for the incidents. Patients and their families had been involved and informed, as had stakeholders and commissioning groups.
- Learning from incidents and complaints was shared within teams; we saw evidence in minutes from team meetings of how incidents and complaints formed a regular agenda item and were discussed openly to ensure learning was shared.
- No 'Never Events' had been recorded by outpatients and diagnostic imaging services. NHS England define Never Events as 'Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'.
- Patient safety alerts were circulated to healthcare providers by the NHS to alert staff to risks that had been identified. We were told that patient safety alerts were shared with staff during team and department meetings. Staff were unable to recall any recent alerts, but one member of staff referred to advice that had been circulated earlier in the year regarding caring for patients during a heatwave. This showed that staff had access to important information that could affect patients.

Cleanliness, infection control and hygiene

- The trust had effective infection control procedures within the outpatients and diagnostic imaging services. We observed staff using personal protective equipment in the form of gloves and aprons. We saw that supplies of personal protective equipment were available in treatment rooms.
- Cleaning procedures were recorded to show scheduled tasks and ensure that procedures were followed.

- Patients told us that they had seen staff wash their hands before and after examinations. They had seen staff using gloves and aprons when required, and disposing of them after use.
- Public waiting areas were clean and tidy. Patients told us that they had always found the hospital to be clean and had no concerns about attending. Some staff told us that there had been additional cleaning completed because our inspection was due, but said "At least it's been done now".
- Staff we spoke with had a good understanding of the principles of infection prevention and control and they were able to describe the training they had received and how they comply with good practice.
- We saw hand-washing guides adjacent to wash basins to remind public and staff of the importance of hand hygiene.
- Hand sanitising gel was located strategically around the department and at entrances and exits with polite notices to remind people to use the gel.

Environment and equipment

- The trust had a responsive maintenance team. Staff told us that issues were dealt with quickly and they did not have any problems obtaining replacement equipment if it was needed.
- Diagnostic and screening equipment was maintained under contract, with regular services undertaken. The superintendent radiographer explained that much the equipment they had was coming to the end of its serviceable life, which meant that breakdowns and minor issues were becoming more frequent; however, no clinics had needed to be cancelled and patients had always been accommodated. A business case had been put forward for two new CT scanners through trust capital funding and they were hoping to have the new machines by April 2015.
- We had cause to visit the records department at the hospital during the inspection because we wanted to investigate an issue about the availability of records within the outpatients department. We saw that the area was very run down. We saw carpets had tears that had been taped over to prevent staff tripping. One area had reported an infestation of fleas in the carpets. The infestation had been dealt with and new floorcoverings had been approved that would prevent further issues, but this work had not yet been carried out. Racking for records was overloaded and we saw large numbers of records stacked loosely and precariously on top of the racks. The environment was not conducive to the safe handling of patient records or the safety and comfort of staff.
- We saw that the trust made good use of information technology. Imaging services were able to input results from scans and x-rays so that consultants at other sites, or from their home if on-call, could access the images and provide remote advice or guidance to staff.

Records

- All of the staff we spoke with, including administrators, clerks, secretaries, nurses and clinicians, told us that the trust had an issue with the availability of patient health records at clinics.
- Staff told us that health records often did not arrive in time for clinics. During September 2014, the trust reported that 10% of records went missing.
- Issues regarding availability of health records had been placed on the Trust Risk Register for the outpatients department. The trust had implemented a number of actions to address the situation, including appointing a manager to collate and map the location of missing record reports and feed the information back to senior managers and to individual departments or staff where they were found to be contributing to the problem.
- Temporary records were created where original sets could not be located in time for clinics; temporary records were prepared by the records staff. They were produced from clinic letters and other information held electronically by the trust, and enabled patients to be seen and treated at the discretion of the doctor. The temporary notes were later married up to the original notes when they were found. This meant that the trust had a system in place to ensure that whenever possible people received appropriate care and treatment if their medical notes were not readily available.
- Patients confirmed that doctors and specialist nurses had updated their health records while they had been present. This meant that records were accurate and protected people against the risk of incorrect information being recorded.
- Staff also told us that clinic letters had caused problems for patients at both Shrewsbury and Telford hospitals. A number of letters had been posted to patients asking them to attend clinics, but the letters had been posted after the date of the clinics in question. This meant that patients missed appointments and then had to wait for

new appointments to be given, during which time their health could deteriorate. We did not speak with any patients at Shrewsbury who had experienced this problem. The trust was aware of this and their enquiries had identified an issue with how and where appointment letters were printed. This issue had been addressed and managers were confident that new systems would prevent further incidents.

Safeguarding

- Staff in the outpatients and diagnostic screening services had a good understanding of safeguarding issues; they were able to describe the forms of abuse that people may suffer and how to escalate any issues they had.
- All staff had received safeguarding training appropriate to their roles. Staff we spoke with were aware of how to report matters.
- Staff were supported by the trust safeguarding team, with a named nurse and named doctor for staff to approach for advice or guidance.

Mandatory training

- In addition to specialist training that individual staff or teams undertook, all staff were required to attend mandatory training. Mandatory training should be completed to ensure staff know how to keep each other, patients and visitors safe.
- Mandatory training was typically undertaken to provide assurance that local policies governing key corporate and risk activities were understood and followed by employees.
- The trust human resources department provided us with the HR Training Report.The trust divide training into statutory training which is required by law and mandatory training which the trust require staff to undertake to fulfill their job role. General Locations which outlined the percentage of staff that had completed mandatory and statutory training between April 2013 and March 2014.
- Statutory training figures for Royal Shrewsbury Hospital outpatients and diagnostic screening services departments averaged 80% against a trust target of 75%.
- Mandatory training figures in the department against a trust target of 75% were only 13%.
- Staff we spoke with knew the areas covered by the mandatory training because they had covered the topics previously or during their induction. However, in these circumstances the trust could not be satisfied that staff had the latest information and advice or had maintained their knowledge base to an acceptable level when training was so low.
- Local managers told us that a combination of factors had impacted on training, including lack of trainers, lack of courses and availability of staff to release to attend training. Alternatives were being considered and some training had been moved to computer-based training, but availability of computer terminals had prevented this from being expanded. One manager explained that six staff had been due to complete their training in June but the course was cancelled at the last minute.

Management of deteriorating patients

- Patients with identified vulnerabilities were dealt with in accordance with their needs. We saw how practice had been changed as a result of enquiries into an incident where a patient had fallen from a chair.
- Patients were encouraged to bring family or friends with them who could support them. When patients attended on their own, staff sat them in areas where they could observe them and react to any assistance that was required.
- We observed a member of staff assisting an elderly patient to their feet and they then used a frame to help them with their mobility.

Nursing staffing

- Staffing of clinics within the outpatients departments was within national guidelines set by the Department of Health. Absences, both planned and unexpected, were covered by staff from the departments or in some cases by bank staff employed by the trust, but with the skills required for the departments concerned. Staff we spoke with were proud that they had been able to provide continuity for their patients from within their own teams.
- Turnover of healthcare workers and nursing staff within outpatient departments was in line with the trust average at 8.15%. Clinic managers told us that most staff move on through personal development.
- We were given examples of how staff numbers were calculated to accommodate the type of clinic and needs of patients who were expected to attend.
- Patients with special needs were usually identified at the time of referral and additional staff could be called

in, if required. Managers described how patients with carers were supported and how carers were encouraged and assisted to provide support during clinic or imaging appointments.

Medical staffing

- Imaging departments provided service on a seven-day basis including out-of-hours cover. Consultant out-of-hours cover was provided on a rota basis and we were shown how consultants could access imaging results remotely and provide advice or guidance to staff on-site. Where required consultants would attend personally.
- The majority of outpatient services were provided on weekdays during core hours of 8am to 8pm. Seven-day working was being proposed and the trust was in consultation with staff and unions regarding changes to working practices. Seven-day working has been highlighted as a priority to increase safety in urgent care and diagnostic support services by Sir Bruce Keogh. Seven-day working in other disciplines will complement the urgent care services and increase flexibility of access for patients.
- Radiology services had made use of locum services to cover absences, but they were actively recruiting and new staff were set to start in November 2014. The locum they had used had been a regular presence and was well known to staff and patients.

Major incident awareness and training

- Staff at all levels were aware that the trust had major incident and business continuity plans. Junior staff stated that they understood they would be given a specific role dependant on the incident and this would be dictated by their supervisor or manager. Clinic managers and more senior staff referred to actions within the plans that they were required to undertake.
- Staff were aware of how to access incident plans on the trust intranet.

Are outpatient and diagnostic imaging services effective?

We saw that care was based on recognised pathways of care and in accordance with national guidance.

Local audits were completed and data shared with the trust, which ensured standards were monitored at an appropriate level.

Clinics followed NICE and recognised national guidance in their specialities. Staff understood the pathways of care and demonstrated that they understood how to recognise when people were not progressing in line with expected outcomes.

Senior staff described how they protected the rights of people who could not make decisions for themselves, either through illness or because of their condition, and how best interest decisions were made in accordance with the Mental Capacity Act 2005.

Evidence-based care and treatment

- We found that clinic specialities worked in accordance with good practice and national guidelines. Staff at all levels understood their role and healthcare and nursing staff told us how they were familiar with expected outcomes for treatment. They explained how they would highlight any issues they saw or any comments patients might make regarding their health to senior staff so that clinicians or specialist nurses could be made aware.
- We saw that audits had been completed on various aspects of the service to ensure that staff understood and followed guidance. Patient satisfaction cards had been used to demonstrate to staff areas that had been commented on, such as staff attitude, resulting in staff awareness increasing and complaints reduced.
- Diagnostic imaging services had employed a locum radiologist for most of the year; this had been caused by a member of staff leaving and difficulty in recruiting to the specialist post. We were told by the head of department that new staff were due to start in November, and further recruitment was planned for the future.

Patient outcomes

- Outpatients and diagnostic imaging services participated in national audits at trust level, including: Diagnostic imaging data set analysis (DID).
- July 2014 figures for date of referral to date of test in diagnostic imaging in the areas of computerised axial tomography, diagnostic ultrasound, magnetic resonance imaging (MRI), nuclear medicine and plain radiography (X-ray) showed that the trust performed better than the average of all English hospitals.

However, during the same period the trust performance was below the national average for fluoroscopy, position emission topography and single photon emission computerised tomography.
- The DID statistics showed that overall trust performance was in line with the national average in most areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked senior staff in both outpatients and imaging services how they catered for patients with special needs such as learning disabilities, or people with mental health issues. They were able to describe the process they would use to ensure that consent to care and treatment had been properly assessed and documented to ensure that best interest decisions had been made. The processes they described mirrored the requirements of the Mental Capacity Act 2005.
- Staff told us how carers or relatives who attended clinics with patients were encouraged to remain and assist whenever this was possible. They told us this enabled the patient to have a familiar person present who they trusted and who could reassure and support them.

Competent staff

- Staff understood their role, felt supported and had regular supervision. While mandatory training attendance figures were low, staff were able to describe the content of training either from memory of their induction or from previous courses; however, they were unable to say if guidance and best practice had changed since they had last been trained. This meant that staff could not be confident that they were using best practice in all areas of their work and interaction with patients.
- Staff told us that they had regular supervision and staff appraisals, where they were able to raise issues or outline their aspirations. We saw evidence in records that confirmed what they told us. However, a number of staff said that it was difficult to progress because they had no time to study; all their time was dedicated to looking after patients and, while they felt staffing levels were adequate, there was no down time in which to expand their knowledge.
- We saw from minutes of meetings that complaints and serious incidents were discussed during team meetings and handover sessions, with learning shared across teams and disciplines. This meant that staff had the opportunity to increase their knowledge and skills and identify areas for improvement.
- Staff had been able to maintain their professional registration, where applicable. Some nursing staff said that they had needed to work at home to provide evidence for their registration because there was no free time at work. They said staff numbers were sufficient to provide a good level of service on a day-to-day basis, but they felt they didn't have time to develop additional skills.

Multidisciplinary working

- One area of good practice was evident in the CT scanning department, where staff had studied the NICE guidance on early intervention for cancer treatment. The guidance requires patients who were believed to have cancer to be scanned within two weeks of initial diagnosis. The team had been working to this guidance and while scans had been completed within two weeks, there had been a delay before reports had been written and shared. The team interpreted the guidance as requiring the scan and report to be completed within two weeks. They changed how they prioritised appointments, leaving three spare appointments in their diary for unforeseen cancer referrals. This enabled them to prioritise those patients and now all cancer referrals were scanned within one week, leaving more than enough time for reports to be completed and forwarded within the two-week time period. In addition to this, if as the day progressed the reserved appointments remained free, staff actively rang wards to see if they had patients waiting for scans who could be brought forward. A member of staff told us "We never waste any slots, we always manage to fill them", demonstrating how the service was not only responsive to patient needs but liaised with other departments to make best use of facilities.
- Patients told us how they had been referred to other services, both at the hospital and at community-based clinics to complement their treatment; these included physiotherapy services, dieticians and speech and language therapists. A relative of an elderly patient explained how they had been referred to the speech and language therapist because their relative had problems when they were drinking fluids and would

aspirate and choke on the drinks. They explained how they now use a thickening agent to help their relative swallow and no longer had to worry about that aspect of their health.
- Staff explained how multidisciplinary meetings took place and clinics were planned so that services complemented each other and enabled patients to attend different clinics on the same visit.

Seven-day services
- Imaging services worked seven days a week and provided services to both inpatient wards and outpatient clinics.
- Outpatients clinics worked five days a week, with some Saturday clinics. They were in the process of consulting with staff and trades unions regarding the implications of moving to a seven-day service. Staff told us that they tried to be flexible and ran clinics until 8pm to enable people who worked, or who needed assistance from relatives who worked, to access services

Access to information
- We saw that the trust made good use of information technology. Imaging services were able to input results from scans and x-rays so that consultants at other sites, or from their home if on-call, could access the images and provide remote advice or guidance to staff.
- Patient health records could not always be located in time for clinic appointments, but in the majority of cases temporary sets were compiled by records staff to enable doctors and specialist nurses to have sufficient information to provide appropriate care, treatment and support. One doctor we spoke with explained how they had access to all clinic letters regarding a patient through the computer terminals in the consulting rooms. They told us it would have to be a very complex case to warrant an appointment being cancelled; they said they were not aware of any appointments being cancelled due to the notes not being available.

Are outpatient and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging services were caring.

Patients we spoke with could not speak highly enough of the staff who had dealt with them.

Staff in all the areas we visited told us that they were proud of how they dealt with patients in their care.

We observed how staff interacted with patients and their families and carers. We saw that compassionate, friendly and professional care was provided.

We observed many instances of staff approaching patients and offering assistance rather than waiting to be asked.

Patients told us that staff had taken time to explain their treatment to them.

Compassionate care
- We observed how staff interacted with patients during their visit to the various services; we saw that staff were friendly and welcoming to patients and their families. We saw staff as they spoke with elderly people and saw that they allowed people time to consider what they had been asked and to provide a response.
- Patients could not speak highly enough of the staff at all levels; one person said, “They were all marvellous, from the char lady to the consultant, it’s like visiting friends”.
- We observed a patient during an MRI procedure and saw how staff supported them throughout the procedure. The process was explained and support and encouragement were provided at each stage.
- One patient told us that staff had been very ‘friendly’, but they were disappointed that they had been asked to sit in a public waiting area while waiting for a scan. They were wearing only a hospital gown; they told us they understood that it was for a short period of time but they had felt conspicuous and embarrassed. They thought a private waiting area would have improved their experience.

Patient understanding and involvement
- Patients told us that they had been fully involved in discussions about their care and the options that were available to them. Patients told us they felt empowered to make decisions and didn’t feel that they were pressured into taking a particular course. One patient said, “They obviously tell you what they think would be best and why they think that, but in the end it’s up to you. I personally think you’d be stupid not to go with their advice, but I know people who’ve refused to have operations or whatever, and they still get the support and everything”.

Outpatients and diagnostic imaging

- Patients told us how staff had allowed them time to consider their responses to questions and how they had been encouraged to ask questions if they were unsure about what they had discussed.
- We saw how patients had been provided with information about their condition or any after care that was required. Sources of additional information and contact numbers were included.

Emotional support

- Patients and family members were very complimentary about the way doctors and senior nursing staff had explained their condition and the impact it might have on their lives. They told us that they had been given clear information in a way that they could understand. Patients said they had been given time to consider the information and to discuss any issues they had. Some patients told us how they had been given the number to the clinic and told they could ring and discuss any issues they had.
- Staff in all the areas we visited told us that they were proud of how they dealt with patients and their families.
- Some staff in diagnostic imaging services said that it was difficult on occasions dealing with people who wanted to know what, if anything, had been identified from their tests. They told us that they were not able to discuss results with patients because they needed to be analysed by the clinicians. Patients were generally aware of this, but many still asked because they were anxious about their condition. Staff explained how they remained professional and courteous in telling patients that the results needed to analysed by the doctor.
- We observed staff as they approached and spoke with the partner of a patient who was undergoing a long MRI procedure. Staff explained the stage they were at in the process, told them that their partner was doing very well and how much longer they might have to wait. The patient's partner was treated with great respect and compassion.

Are outpatient and diagnostic imaging services responsive?

Good

Outpatients and diagnostic imaging services were responsive to people's needs. However, alternative methods were available that enabled people to receive appropriate care even though the process would not have been the first choice of staff had they had access to an appropriate screening room.

We saw how individual clinics had adapted their working practice to enable them to meet national guidance based on the acuity of their patients. This showed how staff at the trust were empowered to change practice in order to improve services for patients.

Patients told us they had been given choices in relation to where and how they were treated.

The trust complaints system provided effective analysis and feedback to the departments, which enabled staff to learn and prevent similar issues arising. Complaints were dealt with in a timely way and complainants were kept informed of the progress of any enquiries and the outcome of complaints. Information on complaints and incidents was shared with commissioning bodies.

Translation services were available to assist people who needed them.

Service planning and delivery to meet the needs of local people

- Outpatient clinics were planned six weeks in advance; letters were sent out to patients confirming appointment times and identifying the clinic concerned. Text messages were sent a few days before the appointment date to remind people of their appointment.
- After their initial referral, depending on the type of clinic involved, their position within the treatment pathway and their personal circumstances, patients could choose to use community-based clinics or either of the main outpatients departments.
- Administration staff told us that if a patient did not attend an appointment, they tried to contact them to see what the reason was for failing to attend and they offered alternative dates to encourage patients to re-engage with the service.
- Evening and weekend clinics were planned to enable people who had difficulty attending clinics during working hours.

Access and flow

- Referral times for outpatients and diagnostic imaging services were in line with national guidelines We saw that outpatients appointments were sent out as block

appointments, which meant that morning or afternoon appointments all had the same start time. We asked the hospital for information regarding how long people had needed to wait after attending the clinics before they were actually seen. We were told that while the arrival time of patients was recorded when they booked in, the trust had no way of monitoring how long people were in the departments before being seen. This meant that some patients had long waits before being seen.

- Most patients we spoke with told us they had only had to wait for short periods of time, between 15 and 30 minutes. However, we did speak with some patients who had been waiting for up to an hour.
- Patients told us that they expected to have to wait at the hospital and they planned their day accordingly, including allowing time for travel and in some cases time to find parking in addition to waiting to be seen. Most patients said they had been seen sooner than they had expected, which resulted in them feeling happy with the service provided.
- As we moved between areas we saw that some patients and their companions had been waiting over 45 minutes.
- X-ray and other clinical imaging services had shorter waiting periods. Patients told us that they had occasionally experienced delays, which staff had explained were due to emergency cases from emergency departments or wards.

Meeting people's individual needs

- Staff explained that patients with complex needs were usually accompanied by carers or family members. Access was available for patients in wheelchairs or those who used walking aids. Staff described how they encouraged and supported carers to enable them to remain with the patient so that they had a familiar presence and could assist with communication when required.
- We saw that patients' relatives were welcomed into consultation rooms if the patient was happy for them to be present. Patients we spoke with described being able to speak openly with doctors and their relatives and their relatives had been able to take an active part in the discussions about options for treatment and associated issues. This was also reflected in comments of doctors and nurses we spoke with.
- The outpatients and diagnostic imaging services did not have dedicated translation services. Staff explained that very few patients attended who were unable to speak or understand what was being said.
- We only spoke with one patient who had difficulty understanding English. They were accompanied by a relative who said they had been pleased to translate and assist staff. They told us they had not needed any additional assistance and were happy with the way they had been dealt with.
- Staff told us that they treat all patients the same, including those with special needs or learning disabilities. They did say that they would take additional care to ensure that the person understood everything that was happening and that they had provided consent or that best interest decisions had been completed correctly to protect their rights. Most people with severe difficulties were accompanied by carers or family members who were able to understand their needs and help them with any anxiety or decisions.
- Staff told us that people with dementia were a regular part of the service, and were almost always accompanied by family or carers, and very often well able to understand and consent to treatment. Family members told us that doctors and nurses had included them in discussions about health and medication requirements.
- Public areas inside outpatients and diagnostic screening areas were well maintained, if sparsely decorated. Seating areas were well lit and comfortable.
- A screening room had been decommissioned in the imaging department and had been converted into a waiting room. The superintendent radiographer explained that the room was still sparse but provided a more comfortable and spacious area for patients to wait.

Learning from complaints and concerns

- The service had a complaints policy and information and support on how to complain was available through the trust Patient Advice and Liaison Service. We saw information leaflets in various locations during our inspection and the trust had a comprehensive section on complaints on their website that included information on what to expect if you complain, and advocacy services to assist people.

Outpatients and diagnostic imaging

- We saw how complaints had been analysed and the learning shared among teams. Regular meetings were held where complaints and incidents were discussed as part of the standing agenda.
- Diagnostic imaging had created dedicated feedback forms that were available for patients to complete or take away and provide their response later. These had been used to feed back to staff areas highlighted by patients to enable them to improve the service provided.
- Before our inspection visit we had received information from individuals and patient groups that they had been sent appointment letters for clinics that had already taken place. Other patients told us that they had attended appointments only to be turned away when they arrived because clinics had been cancelled. We found that the trust had responded to the complaints and identified the issue. The system for printing and checking letters had been changed to prevent further incidents.

Are outpatient and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging services were well led.

Diagnostic imaging formed part of the trust's Support Service Care Group. Outpatient departments formed part of the trust's Scheduled Care Group, which was led by the assistant chief operating officer supported by the group head of nursing and group medical director.

We found that managers and clinic leads were liked and respected by their staff; they understood their role and the importance of their department or unit to the trust.

Systems were in place to enable managers to monitor and influence the work in their domain. Regular meetings took place between senior managers and department leads. Issues from teams were highlighted and information and feedback from senior managers and board-level decisions were cascaded down.

Trust policies and procedures were understood by staff and followed; however, issues with training were not always addressed or escalated sufficiently to ensure that staff received the most recent training in all areas.

We saw evidence of good communication and liaison between managers at different sites regarding their services, which ensured good practice or issues were shared.

Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision and values. Staff believed that patients were looked after well and the trust did what it could, given the financial position. The majority of staff we spoke with believed that patient care and safety had improved in recent years.
- Individual teams and their managers were aware of key performance indicators for their service and care was based on recognised pathways. Staff told us they felt part of the trust and understood their role in achieving goals.

Governance, risk management and quality measurement

- Outpatients departments and diagnostic imaging departments provided performance data to the trust board on a monthly basis. Matrons and department heads met regularly to discuss performance, staffing levels and skill mix.
- Referrals from GPs to clinic services followed accepted practice and the trust's standard operating procedures.
- Staff understood their role and function; they told us they were proud to work at the trust and of the relationships with patients and the wider health community.
- We saw that there were systems in place to monitor performance within teams. Regular meetings took place where learning was shared and performance discussed.
- We saw that clinics were planned to maximise capacity; staff and managers told us the only way they could increase capacity was to move to seven-day working. Space and time would not allow any expansion of services within current practice.
- We saw minutes of meetings that confirmed that complaints and serious incidents were discussed to enable learning between and within teams. Staff told us that important incidents were shared across the trust and not restricted to one site or one team.

Outpatients and diagnostic imaging

Leadership of service

- We found that local leadership was good; staff were supported to do their role and we had many examples of senior staff up to matron level assisting in clinics during busy periods.
- Liaison between managers at different sites but in the same field was excellent.
- The trust had set a target for 75% of staff to complete their mandatory training. However, the low numbers of staff who had completed this training suggested that it was not taken seriously. Staff told us there were no courses available. This had been highlighted at team meetings and managers had escalated the problem, but no additional resources had been provided.
- We saw minutes of meetings that confirmed that complaints and serious incidents were discussed to enable learning between and within teams. Staff told us that important incidents were shared across the trust and not restricted to one site or one team.
- Staff told us they felt informed about important issues within the trust and at their own site; they said these were discussed at team meetings and they also received emails, and had access to the trust newsletters and information through the intranet. However, many staff said they did not see executive-level staff in the departments.

Culture within the service

- Managers understood their role, and were aware of their unit's function and importance to the trust. They understood the difficulties staff faced with issues such as capacity and they represented their interest at senior management meetings.
- Staff told us they had confidence in their local managers, they felt supported by them and believed they were approachable.
- Local managers were visible to their teams and staff told us how senior staff would often provide assistance during busy period.
- As part of our intelligence gathering process prior to the inspection we look at information from a number of sources. This includes information posted on our website through the 'share your experience' system and we receive letters from patients visitors and staff. we hold focus groups and encourage people to contact us with details of their experiences both good and bad.

  One such communication suggested that if staff at the hospital complained or made a fuss about an issue, managers would try to move them and exclude them from being part of the team. The information related to part of the outpatients and diagnostic imaging services. During the inspection of these services at the Royal Shrewsbury Hospital, in addition to speaking with staff in focus groups, we spoke with 29 staff either individually or in small groups of two or three. None of the staff we spoke with told us they had experienced or witnessed any unfair treatment.

Public and staff engagement

- Analysis of complaints and comments was completed at trust level; however, we were shown examples of how local information had been used in some areas to identify issues. Diagnostic services had introduced a patient feedback form; comments had identified that staff were not always as welcoming as patients would like. These findings were fed back to staff during meetings and resulted in staff being more aware of how their actions and behaviour affected patients. We were advised that comments about staff attitude reduced after the feedback was given.
- Complaints were dealt with at trust level but we saw evidence of how complaints had been analysed and results shared with teams.

Innovation, improvement and sustainability

- Seven-day working has been proposed in clinics and areas of imaging that do not already provide seven-day cover.
- New CT scanners have been approved, which will increase patient flow and capacity.
- We were told that staff absences were covered from within clinics' own staff. The cost of covering for absences was met through utilising staff who by virtue of the NHS agenda for change were on protected pay rates. This had meant that it was cheaper for the trust to pay these staff to work additional hours than to use bank or agency staff. The protect pay rates were due to continue for another 12 months, after which managers told us they did not know how they would finance cover. This meant that the system was not sustainable in the long term.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had good safeguarding procedures in place. The safeguarding team had links in every department where children were seen, with safeguarding information shared across the trust.
- The trust had appointed an Independent Domestic Violence Advisor. The post had been supported through funding from the Police Crime Commissioner because of the excellent outcomes for people recorded by the trust. Referrals from the trust to the Multi Agency Risk Assessment Conference had been endorsed as excellent practice by Coordinated Action against Domestic Abuse (CAADA). CAADA a national charity supporting a multi-agency and risk-led response to domestic abuse.

Areas for improvement

Action the hospital MUST take to improve

- The trust must review the levels of nursing staff across A&E critical care and end of life services to ensure they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that further service development and learning can take place.
- Ensure that staff are able to access mandatory training in all areas.
- Ensure that accident and emergency and all surgical wards are able to access all the necessary equipment to provide safe and effective care.
- Review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.
- Ensure that mortuary services are safe through maintenance and security of this area.

Action the hospital SHOULD take to improve

- Review the availability of support staff across the seven-day week to improve outcomes for patients.
- Review the achievements and actions taken to address the targets set nationally within A&E and across audits in medicine and in end of life care.
- Review the specific equipment required to support an effective service for those people living with dementia.
- Review medicines storage in surgery.
- Review the capacity and flow within surgery and critical care to reduce waiting times and improve services to patients.
- Review the provision of the end of life service to ensure that patients can access this service throughout the week.
- Review the communication between senior managers and staff to ensure that initiatives and issues are captured.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Deceased patients were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance of the fridge storage area

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Bereaved relatives viewing their relative in the mortuary are not treated with consideration or respect because the viewing room environment for children and adults is not considerate to a family's needs.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust must review the levels of nursing staff across A&E critical care and end of life services to ensure they are safe and meet the requirements of the service. There were not sufficient paediatric trained nurses in the A&E department. There were not sufficient general nurses in the A&E or end of life services. The critical care unit was not staffed in accordance with national guidance.

This section is primarily information for the provider

Compliance actions

The trust must ensure that staff are able to access mandatory training in all areas.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The trust must ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that service development and learning can take place. The trust must review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The trust must ensure that A&E and all surgical wards are able to access all the necessary equipment to provide safe and effective care. This includes defibrillators and ECG machines in the A&E department and a variety of equipment in the surgery department, especially when new wards are created.