Shrewsbury and Telford Hospital NHS Trust

Inspection report

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**
Are resources used productively?	**Requires improvement**
Combined quality and resource rating	**Inadequate**

Summary of findings

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

Background to the trust

Shrewsbury and Telford Hospital NHS Trust has approximately 628 inpatient beds and 43 day-case beds and 44 children's beds located across two acute locations: The Princess Royal Hospital which is located in Telford and Royal Shrewsbury Hospital which is located in Shrewsbury. These two hospitals serve an approximate combined population of 420,000. The trust is a major trauma centre for the region. The trust also operates three midwifery led units (MLU) in the community: Bridgnorth MLU, Ludlow MLU and Oswestry MLU. Consultant-led clinics are also held at Wrekin Community Hospital. The number of staff employed by the trust as of April 2018 was 5,053. The trusts' services are commissioned by Telford and Wrekin Clinical Commissioning Group (CCG), Shropshire CCG and Powys Training Health Board.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total Staffing; trust website)

Overall summary

Our rating of this trust went down since our last inspection. We rated it as Inadequate 

What this trust does

Shrewsbury and Telford Hospital NHS Trust has approximately 628 inpatient beds and 43 day-case beds and 44 children's beds located across two acute locations: The Princess Royal Hospital which is located in Telford and Royal Shrewsbury Hospital which is located in Shrewsbury. These two hospitals serve an approximate combined population of 420,000.

The trust is a major trauma centre for the region. The trust also operates three midwifery led units (MLU) in the community: Bridgnorth MLU, Ludlow MLU and Oswestry MLU. Consultant-led clinics are also held at Wrekin Community Hospital.

The number of staff employed by the trust as of April 2018 was 5,053.

The trusts' services are commissioned by Telford and Wrekin Clinical Commissioning Group (CCG), Shropshire CCG and Powys Training Health Board.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total Staffing; trust website)

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 21 and 23 August 2018, we inspected the core services of medical care, surgery, critical care and maternity at Royal Shrewsbury Hospital. We also inspected the core services of medical care, surgery and critical care at The Princess Royal Hospital.

Between 29 and 31 August 2018, we inspected the core services of urgent and emergency care and end of life care at Royal Shrewsbury Hospital. We also inspected the core services of urgent and emergency care, maternity and end of life care at The Princess Royal Hospital.

We also carried out unannounced inspections on 7 September 2018 to Royal Shrewsbury Hospital and The Princess Royal Hospital.

We carried out the well led review from 19 to 21 September 2018.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well led key question at trust level. Our findings are in the section headed 'Is this organisation well led?'

What we found

Overall trust

Our rating of the trust went down. We rated it as inadequate because:

- The Princess Royal Hospital, Telford and Royal Shrewsbury Hospital, Shrewsbury were rated as inadequate overall.
- In four services, safe and well-led was rated as inadequate.
- In many services, overall, safe, effective, responsive and well-led were rated as requires improvement.

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/RXW/reports.

Are services safe?

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

- Urgent and emergency care and maternity services at both sites were rated as inadequate for safe.
- Medical care, surgery, critical care, end of life at both sites were rated as requires improvement.
- Our rating of medical care and end of life services at Royal Shrewsbury Hospital went down.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Medical care, surgery, critical care, end of life at both sites were rated as requires improvement. Urgent and emergency care services at The Princess Royal Hospital and maternity services at Royal Shrewsbury Hospital were also rated as requires improvement.
- Urgent and emergency care services at Royal Shrewsbury Hospital and maternity services at The Princess Royal Hospital were rated as good.

Summary of findings

Are services caring?

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

- Medical care at The Princess Royal Hospital was rated as requires improvement.
- All other core services inspected across both sites were rated as good.
- Staff cared for patients with compassion. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

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

- Urgent and emergency care, surgery, critical care, end of life care at both sites were rated as requires improvement. Medical care at The Princess Royal Hospital and maternity services at Royal Shrewsbury Hospital were also rated as requires improvement.
- Maternity services at The Princess Royal Hospital and medical care at Royal Shrewsbury Hospital were rated as good.

Are services well-led?

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

- Two services at the Royal Shrewsbury and two at Princess Royal were rated as inadequate for well-led overall.
- In many services well-led were rated as requires improvement
- We rated well-led at the trust as inadequate overall.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in end of life care services at both sites, maternity at The Princess Royal Hospital and critical care at Royal Shrewsbury Hospital.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including eight breach(es) of legal requirements that the trust must put right. We also found 81 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of its services.

Action we have taken

We issued requirement notices to the trust and took enforcement action. Our action related to breaches of legal requirements at a trust-wide level and in urgent and emergency care, medical care, surgery, critical care, maternity and end of life.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- The critical care service and its staff had demonstrated improvement and learning as part of their journey to achieving the trust's Diamond Excellar award.
- The postnatal ward had received the exemplar ward diamond status which is the highest possible, staff were very proud of being the first ward within the trust to be awarded this level. To achieve this level the ward met high standards in a number of key areas for example; caring for women and babies, medicine management, leadership, nutrition, hydration, cleanliness, safety and record-keeping.
- The trust has been selected as one of eight trusts to work with National Health Service Improvement and Hospice UK on the ELCHIP (End of Life Care in Hospital Inpatients) project, to improve end of life care in the emergency and acute setting.
- The end of life care (EoLC) team and bereavement service had introduced a bereavement visit lanyard for staff to wear when accompanying relatives on bereavement visits. This was implemented as learning from an incident in which a member of staff accompanying a bereaved parent was approached by a colleague inappropriately because they had not identified the nature of the situation. The new lanyard was discreet and branded with the Swan logo, which indicated to staff that they should not interrupt the visit.
- There was a demonstrable, sustained drive to improve the sensitivity of the delivery of care by all staff in the hospital. This included a review of the language used to describe meetings and bereavement cards and the supply of more personal clothing to replace standard-issue hospital items.
- EoLC champions and volunteers had attended 'touch training' that enabled them to provide hand-holding therapy during the final hours of life. This helped to reduce anxiety and had received positive feedback from relatives.
- A photographer was available on demand to take memento photographs of hand-holding in the last moments of a patient's life. Staff said relatives appreciated this service as it helped them to focus on the tranquillity of the final moments. The photographer provided photographs within one hour of taking them and delivered them if relatives had left the hospital by the time they were ready.
- There was a significant drive from staff to engage colleagues, the trust and the public in discussions of EoLC. They delivered a well-attended Dying Matters week event, issued certificates of achievement for ward staff who receive compliments for their work and worked with the Transforming Care Institute to embed discussions of EoLC into ward discussions.
- The trust had recognised teams in the acute medical unit and in the emergency department with awards for their work to improve the care and experience of patients at the end of life.

Areas for improvement

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to 12 services: urgent and emergency care, medical care, surgery, critical care, maternity, end of life care.

Summary of findings

For the overall trust:

- Ensure compliance with the requirements of the fit and proper person's regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
- Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks.

In urgent and emergency care at The Princess Royal Hospital:

- Ensure nurse staffing is adequate to keep all patients safe, including paediatric patients.
- Ensure medical staffing is adequate to keep all patients safe, including paediatric patients.
- Ensure staff receive appropriate mandatory training to undertake their roles in a safe and effective way.
- Ensure rooms allocated for use with psychiatric patients meet requirements to keep patients safe.
- Ensure they enable staff to consistently manage and review deteriorating patients in line with national guidance. The trust should also review their policies regarding managing deteriorating patients.
- Review national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.

In medical care at The Princess Royal Hospital:

- Ensure that patients individual needs are assessed and planned for. This includes needs that are related to any learning disabilities, pressure care, nutrition and hydration and end of life care needs.
- Ensure that all patients are consistently treated with dignity and respect.
- Ensure that during periods of increased demand and capacity safe systems are in place to manage this.
- Ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm.
- Ensure that effective systems are in place to reduce the risk of safety incidents from reoccurring.
- Ensure that sufficient permanent staff are employed to keep people safe from avoidable harm and abuse.
- Ensure staff complete mandatory training in line with the trust targets.
- Ensure that no patients are unlawfully detained at the hospital.

In surgery at The Princess Royal Hospital:

- Ensure all controlled drugs are checked daily and evidence is documented.
- Ensure all medical staff are trained to the required level of safeguarding for both adult and children.

In critical care at The Princess Royal Hospital:

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.
- Ensure there are effective systems to assess, monitor and review the performance of the unit so the safety and quality of care provided can be improved.

In maternity at The Princess Royal Hospital:

- Ensure that the low risk midwifery pathway is robust and women access the correct pathway of care and give birth in the correct area according to their assessment of risk.

Summary of findings

- Ensure staff complete mandatory training in line with the trust target.
- Ensure staff complete adult safeguarding training in line with the trust target.
- Ensure that the lone working policy is adhered to ensure staff safety.
- Ensure that the women's weight is recorded on the prescription charts.
- Ensure handovers are completed regularly and high-risk women in labour are reviewed by medical staff.
- Ensure high risk women are reviewed in the appropriate environment by the correct member of staff.
- Ensure the correct number of anaesthetists are employed as recommended by the Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland 2013 guidelines for obstetric anaesthesia.
- Ensure that the community midwives are carrying the correct equipment to carry out their work in line with best practice.
- Ensure Maternity Early Obstetric Warning Score (MEOWS) charts are fully completed.
- Ensure all staff complete the cardiotocography (CTG) training defined by the service.
- Ensure that prescription and observation charts are stored confidentially.
- Ensure grading of incidents reflects the level of harm.
- Ensure that the Head of Midwifery has direct access to the board in line with better births 2016.

In end of life care at The Princess Royal Hospital:

- Ensure that staff store patient records securely, complete the end of life plan, ensure equipment inventories for syringe drivers are up to date and that mortuary staff have access to the trust intranet, policies and procedures.
- Ensure that end of life performance measurements is part of the trusts quality dashboards and routinely audit and act on data within the end of life care service to drive improvement.
- Ensure that all staff understand and implemented the SWAN scheme and or ensure that resources for the SWAN scheme are prioritised.
- Ensure that the end of life care team have its own dedicated risk register that reflects the risks and management of risks within the service.
- Ensure that end of life patients have appropriate access to mental health input or advice.
- Ensure that equipment is stored safely and that ward areas are free from clutter.

In urgent and emergency care at Royal Shrewsbury Hospital:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients.
- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts.
- Ensure they provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance.
- Ensure that all assessment forms are appropriate and that early warning scores are recorded on the correct, coloured documentation and not photocopies.

Summary of findings

- Review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. This includes the 4-hour waiting target.

In medical care at Royal Shrewsbury Hospital:

- Ensure that the mandatory training rates meet the trust target.
- Ensure that safeguarding training rates meet the trust target.
- Ensure mental capacity assessments are consistently carried out where required.
- Ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance.
- Ensure that all equipment is reviewed within trust and manufacturer guidelines.
- Ensure that dietary risks to renal patients are identified and actioned appropriately.
- The trust must improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis.
- Ensure best practice is followed when preparing, administering and storing medicines.
- Ensure that it has appropriate processes and governance in place to ensure that patients detained under the Mental Health Act 1983 receive the right to appeal the detention.

In surgery at Royal Shrewsbury Hospital:

- Ensure sufficient permanent staff are employed to keep people safe from avoidable harm and abuse and that they attend safeguarding training in line with the trust target.
- Ensure all staff complete mandatory training, Mental Capacity Act training and become familiar with lessons learnt.
- Ensure records are stored safely and confidentiality is maintained.
- Ensure staff are confident with the procedure for sepsis management.

In critical care at Royal Shrewsbury Hospital:

- Ensure there are sufficient staff (physiotherapists, nurses, dieticians) with the right skills to meet patients' needs and meet required intensive care standards.
- Ensure staff have training and understanding of deprivation of liberty safeguards to ensure that the requirements of the regulations are appropriately met.
- Ensure arrangements for the availability of the hospital at night team are robust to ensure there are sufficient and appropriate staff available to assess and treat deteriorating ward patients.
- Ensure consent to care and treatment including deprivation of liberty must be sought in line with legislation and guidance.
- Ensure staff have training and appropriate knowledge of the deprivation of liberty safeguards.
- Ensure multidisciplinary team (MDT) working is joined up across critical care to ensure there is coordinated MDT patient review and management.

In maternity at Royal Shrewsbury Hospital:

- Provide an MLU environment that is safe and fit for purpose.
- Ensure that environmental risks are identified and acted on in a timely way.

Summary of findings

- Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe.
- Take account of the report from the Royal College of Obstetricians and Gynaecologists (RCOG) review of current practice within maternity services in 2017, when this is released. In respect of the outcome of the report, formulate action plans to improve maternity services.
- Review the processes around escalating women who are at high risk so that these women who present at the midwifery led unit/day assessment unit receive a medical review without delay.
- Review the policy on reduced fetal movements so there is a clear and defined pathway for midwives and sonographers to follow.
- Ensure the Head of Midwifery has direct access to the board in keeping with recommendations from 'Spotlight on Maternity' 2016.
- Ensure complaints are addressed within the timescale of your complaints policy.
- Ensure National Institute of Health and Care Excellence (NICE) operational policies and guidelines are reviewed in date.
- Ensure that, in line with the 'Lone Working & Peripatetic Policy', midwives use the safety devices when working alone.

In end of life care at Royal Shrewsbury Hospital:

- Ensure staff are supported to report incidents.
- Review staffing levels against Royal College of Physicians guidance.
- Ensure doctors out of hours have the capability and confidence to review patients at the end of life, including through prescribing.
- Ensure records are properly completed and used by appropriate staff including EOLP.
- Ensure governance processes are fit for purpose, support those responsible for service delivery and result in improved safety and effectiveness.

Action the trust SHOULD take to improve

We told the trust it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

For the overall trust:

- Engage staff in the strategic direction of the trust and services.
- Ensure feedback from staff is acted on and responded to in a timely way.
- Ensure the executive team are seen as visible and approachable to all services.

In urgent and emergency care at The Princess Royal Hospital:

- Ensure they respond to complaints in an appropriate timescale.
- Consider bariatric facilities in waiting areas.
- Ensure that data protection regulations are adhered to.

In medical care at The Princess Royal Hospital:

- Continue progress towards implementing a sustainable seven-day service.

Summary of findings

In surgery at The Princess Royal Hospital:

- Monitor that all staff complete their mandatory training.
- Monitor staff compliance with the infection control practices across the surgical service.
- Monitor how records are stored safely and confidentially maintained.
- Continue to work to improve the admitted referral to treatment time.
- Review the complaint handling process.

In critical care at The Princess Royal Hospital:

- Ensure mandatory training compliance levels for medical staff are improved to comply with trust targets.
- Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance.
- Ensure monthly mortality and morbidity meetings take place, are recorded and any learning shared with the appropriate parties.
- Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are identified and included on the local risk register.
- Ensure the cover provided by the critical care outreach team complies with required standards.
- Ensure the cover provided by the hospital at night team is safe.
- Ensure that appropriate audits are carried out and used to improve the performance of the unit and outcomes for patients.
- Ensure all relevant policies are up to date.
- Ensure that compliance with Mental Capacity Act and Deprivation of Liberty training complies with trust targets.
- Ensure there are adequate counselling arrangements for patients.
- Ensure follow-up clinics are available and offered to suitable patients.
- Ensure access and flow into and out of the critical care unit is improved so patients receive the right care at the right time and in the right place.
- Ensure the risk register in use within the department includes all risks identified by the unit and actions discussed to ensure all relevant parties are kept up to date.
- Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.
- Review the provision of physiotherapy resource to improve compliance with National Institute of Health and Care Excellence (NICE) Guidance 83 (Rehabilitation after critical illness in adults).
- Ensure the leadership of the critical care unit is effective.

In maternity at The Princess Royal Hospital:

- Ensure staff are aware and can explain learning from serious incidents and complaints.
- Have identified a plan to work towards compliance with the Department of Heath recommendations 2013 to have ensuite facilities in a labour room.

Summary of findings

- Ensure that SBAR forms are fully completed.
- Ensure that midwives prescribing antibiotics comply with the medications policy.
- Ensure all incidents are reviewed and closed in a timely manner.
- Ensure staffing is appropriate on the postnatal ward to enable midwives to care for babies on transitional care.
- Ensure that there is a system in place to know that equipment has been cleaned.
- Ensure that medicines prescribed are in line with the antibiotic formulary.
- Ensure that the safety thermometer results are displayed for staff and the public to see.
- Ensure the time women request an epidural to the time they received one is monitored.
- Ensure the 2018 dashboard is colour coded and an agenda item at maternity governance meetings.
- Share the plans to implement a new process to replace statutory supervision of midwives which ceased in April 2017 with all staff.
- Ensure women receive carbon monoxide screening in line with national guidance.
- Ensure that all leaflets are accessible in different languages and easy to read versions.
- Ensure displays and leaflets are available to inform women how to complain.
- Have a defined maternity strategy.
- Ensure staff are aware of the vision of the service and the trust's vision and values.
- Ensure the executive team are visible and supportive during challenging times within the maternity service.
- Ensure staff morale is reviewed and plan to improve the staff survey results.
- Ensure multidisciplinary attendance at the maternity governance meetings.
- Ensure labour ward forum meetings are held at regular intervals.
- Ensure that all risks within maternity services are added to the risk register.
- Ensure staff are involved with proposed changes and developments.
- Ensure staff engagement and involvement with service changes is improved.

In end of life care at The Princess Royal Hospital:

- Ensure that the specialist palliative care team maintain a central list of patients who were receiving specialist palliative care or details of the ward areas where they were being cared for.
- Ensure that it provides it meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is a 9am to 5pm, seven-days per week.
- Ensure that medical staffing meets the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care standard (NCPC) which states there should be a minimum of one consultant per 50 beds.
- Ensure that its end of life strategy links to national and local objectives in relation to improving end of life care and definitive timescales and commitments to achieve service improvements.

Summary of findings

In urgent and emergency care at Royal Shrewsbury Hospital:

- Should review all policies regarding managing deteriorating patients, especially the use of a bleep system to prioritise patients with sepsis.
- Should review departmental risk registers to ensure actions are updated in a timely manner.

In medical care at Royal Shrewsbury Hospital:

- Should improve training rates for learning disability training among staff within the service.
- Should improve its timeliness when investigating complaints.

In surgery at Royal Shrewsbury Hospital:

- Continue progress to integrate a seven-day service.
- Address issues regarding staff not adhering to infection control policy
- The management of complaint handling should be reviewed.
- Attend to building repairs in a timely way.

In critical care at Royal Shrewsbury Hospital:

- Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance.
- Ensure monthly mortality and morbidity meetings take place, are recorded and any learning shared with the appropriate parties.
- Ensure the cover provided by the critical care outreach team complies with required standards.
- Ensure that appropriate audits are carried out and used to improve the performance of the unit and outcomes for patients.
- Ensure all relevant policies are up to date.
- Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.
- Review the provision of physiotherapy resource to improve compliance with National Institute of Health and Care Excellence (NICE) Guidance 83 (Rehabilitation after critical illness in adults).
- Ensure the leadership of the critical care unit is effective.
- Ensure there are effective systems to assess, monitor and review the performance of the unit so the safety and quality of care provided can be improved.

In maternity at Royal Shrewsbury Hospital:

- Engage with staff about changes and developments and include staff in discussions around these.
- Encourage and facilitate managers and staff to be innovative and to discuss their ideas for positive changes.
- Ensure vision, strategy and trust values are shared with all staff, including how staff roles fit around this.

In end of life care at Royal Shrewsbury Hospital:

- Review service provision against National Institute of Health and Care Excellence guidance.

Summary of findings

- Ensure junior doctors continue to be engaged in training and have the opportunity to request more advanced training where needed.
- Review the governance structures in place to ensure they are fit for purpose, result in meaningful change and result in timely progress.
- Review the results of the bereavement survey to identify trends and key issues, as outlined in our evidence appendix.
- Review staffing levels for the bereavement office.
- Ensure data is collected with regards to patients' preferred place of care, including when this has been offered and when it has been achieved.
- Establish a more robust system of identifying end of life care patients.
- Embed the use of the end of life plan to improve patient experience in the last days and hours of their life.
- Fast track discharges should be monitored and audited.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well led at the trust as inadequate. This went down from the previous inspection. We rated as inadequate because:

- Not all trust leaders had the right skills and abilities to run a service providing high-quality sustainable care.
- Leaders were not always visible and did not work together as a cohesive team.
- Trust staff did not have confidence in all members of the executive team.
- The strategy and plans focused on the long term and did not detail how the trust would address key issues in the short term. There was a lack of clinical strategy that engaged services across the trust.
- Staff informed us they did not always observe or experience members of the executive team displaying the trust values in their behaviours.
- A policy was in place regarding Fit and Proper Person checks to ensure compliance with the regulation. However we found gaps in all the seven board member files we reviewed.
- Staff reported a culture of bullying and harassment and at times we found a culture of defensiveness from the executive team.
- Governance systems were ineffective to ensure quality services were provided.
- The board assurance framework lacked clarity and coherence.There was a lack of accountability and ownership of patient safety agendas at board level.
- The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, controls and assurance of mitigation at board level were not always evident.

Summary of findings

- The disjointed approach of the leadership team and ineffective systems meant that the trust did not maximise opportunities to learn and improve.
- Staff felt they were not listened to and were sometimes fearful to raise concerns or issues.

However:

- The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The trust was committed to improving services by promoting training, research and innovation.
- The trust engaged with patients, staff, the public and local organisations to plan and manage services.
- The Chair and some of the executive directors acknowledged that work was required urgently to address the trust culture and there was a vision for where the trust wanted to be.
- Staff had confidence in the recently established freedom to speak up function.

Use of resources

A report of an inspection of the trusts' use of resources, carried out by NHS Improvement, is available at www.cqc.org.uk/provider/RXW/Reports

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Nov 2018	Requires improvement ➔➔ Nov 2018	Good ➔➔ Nov 2018	Requires improvement ➔➔ Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Princess Royal Hospital	Inadequate ↓ Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018
Royal Shrewsbury Hospital	Inadequate ↓ Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018
Bridgnorth Community Hospital	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Ludlow Community Hospital	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Oswestry Maternity Unit	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Wrekin Community Clinic, Euston House	N/A	N/A	N/A	N/A	N/A	N/A
Overall trust	Inadequate ↓ Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018

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

Ratings for The Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018
Medical care (including older people's care)	Requires improvement →← Nov 2018	Requires improvement ↓ Nov 2018	Requires improvement ↓ Nov 2018	Requires improvement ↓ Nov 2018	Requires improvement ↓ Nov 2018	Requires improvement ↓ Nov 2018
Surgery	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018
Critical care	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018
Maternity	Inadequate Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Services for children and young people	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
End of life care	Requires improvement →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Inadequate ↓ Aug 2018	Requires improvement →← Aug 2018
Outpatients and diagnostic imaging	Requires improvement Oct 2014	N/A	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Overall*	Inadequate ↓ Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018

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

Ratings for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018
Medical care (including older people's care)	Requires improvement →← Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Good →← Nov 2018	Requires improvement ↓ Nov 2018	Requires improvement ↓ Nov 2018
Surgery	Requires improvement →← Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018
Critical care	Requires improvement →← Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018
Maternity	Inadequate Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Services for children and young people	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
End of life care	Requires improvement →← Nov 2018	Requires improvement →← Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓↓ Nov 2018	Requires improvement ↓ Nov 2018
Outpatients and diagnostic imaging	Requires improvement Oct 2014	N/A	Good Oct 2014	Good Oct 2014	Good Oct 2014	Good Oct 2014
Overall*	Inadequate ↓ Nov 2018	Requires improvement ↓ Nov 2018	Good →← Nov 2018	Requires improvement →← Nov 2018	Inadequate ↓ Nov 2018	Inadequate ↓ Nov 2018

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

Ratings for Bridgnorth Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and Gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall*	Good ↓ Aug 2017	Good ↓ Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Good ↓ Aug 2017	Good ↓ Aug 2017

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

Ratings for Ludlow Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and Gynaecology	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall*	Requires improvement ↓ Aug 2017	Good ↓ Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Requires improvement ↓ Aug 2017	Requires improvement ↓ Aug 2017

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

Ratings for Oswestry Maternity Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and Gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall*	Good ↓ Aug 2017	Good ↓ Aug 2017	Good →← Aug 2017	Good →← Aug 2017	Good ↓ Aug 2017	Good ↓ Aug 2017

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

Ratings for Wrekin Community Clinic, Euston House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients	N/A	N/A	N/A	N/A	N/A	N/A
Overall*	N/A	N/A	N/A	N/A	N/A	N/A

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

The Princess Royal Hospital

Apley Castle
Telford
Shropshire
TF1 6TF
Tel: 01952641222
www.sath.nhs.uk

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust has approximately 628 inpatient beds and 43 day-case beds and 44 children's beds located across two acute locations: The Princess Royal Hospital which is located in Telford and Royal Shrewsbury Hospital which is located in Shrewsbury. These two hospitals serve an approximate combined population of 420,000. The trust is a major trauma unit for the region. The number of staff employed by the trust as of April 2018 was 5,053. The trusts' services are commissioned by Telford and Wrekin Clinical Commissioning Group (CCG), Shropshire CCG and Powys Training Health Board.

At The Princess Royal Hospital in Telford, there is an accident and emergency department and a minor injuries unit.

The Princess Royal Hospital provides a range of hospital services, including general medicine including elderly care, elective surgery and a range of outpatient services.

The Princess Royal Hospital is also the main specialist centre for inpatient head and neck surgery and inpatient women and children's services. There is also hyper/acute stroke and stroke rehabilitation services, as well as a dedicated falls prevention and screening service and a dedicated cardiac catheter lab.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total staffing; trust website)

Summary of services at The Princess Royal Hospital

Inadequate 

Our rating of services went down. We rated them as inadequate because:

- Our rating of safe was inadequate overall. At times of high operational pressures patients were not always assessed and treated in a safe and suitable environment. Services did not always manage patient safety incidents well. The deteriorating patient was not always recognised within urgent and emergency care services to ensure appropriate and timely care was provided. Not all services had sufficient numbers of permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse. Staff completion data for mandatory training did not meet the trust targets, including Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. There was no data available for adult safeguarding training for medical staff.
- Our rating of effective remained requires improvement overall. Services monitored the effectiveness of care and treatment and used the findings to improve them. However, effective action was not always taken in response to poor audit results to drive improvement.

Summary of findings

- Our rating of caring remained as good overall. Staff delivered compassionate care, however we did see examples where compassionate care was not delivered in a consistent manner. Privacy and dignity was maintained and promoted by most services, however we found the trust's approach to boarding meant patients' dignity was not always promoted.
- Our rating of responsive remained as requires improvement overall. The trust did not always plan and provide services in a way that met the needs of local people. Not all services always took into account the individual needs of patients.
- Our rating of well-led went down to inadequate overall. Staff reported a disconnect between them and the senior management team and board. There were systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, timely and effective action was not always taken to mitigate risk. The trust did not always use a systematic approach to continually improve the quality of its services or safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

Urgent and emergency services

Inadequate 

Key facts and figures

Princess Royal Hospital Emergency Department (ED) provided care and initial treatment to patients presenting with injuries or illness in the event of an accident or emergency. Princess Royal Hospital had a majors unit as well as a minor injuries unit and a clinical decision unit, there was also an urgent care centre due to open in 2018. The building work for this centre was underway at the time of our inspection.

Both sites across the trust have acute medical units where patients are initially admitted from either the emergency department or through GP referral (referral via the care co-ordination centre). Patients with conditions that can be diagnosed/treated without the need for admission may be seen and treated in the ambulatory emergency centre (AEC) which is led by GP's and advanced nurse practitioners.

The internal layout of the Emergency Department (ED) comprised of a main waiting area. Within this area there were two hatches; one where patients could book in and see a streaming nurse (for minor injuries). A triage room led off the main waiting room. Within the treatment areas were four 'minors' cubicles (for patients with minor injuries and illness), eight 'majors' cubicles (for patients with major illness or injury) and a paediatric treatment room. In addition, there were two 'pit stop' cubicles where rapid assessments took place following triage, and two areas for 'fit to sit' patients. One of these cubicles had chairs where patients who were well enough could sit and await further assessment. The other 'fit to sit' cubicle had a bed where patients could be examined individually if necessary. There was also a separate treatment room which was generally used for contagious patients. If this room was in use, infectious patients were located in the ED theatre. The ED theatre was otherwise used for procedures such as minor suturing. There was also a plaster room to use when the fracture clinic facilities were not available. There were two other rooms; one which was used to locate psychiatric patients and one which was used as a family room. A 'Swan' room could be used to locate patients who were at the end of life in the department. Please see the report about End of Life Care at the Princess Royal Hospital for more details. The resuscitation area comprised a large room with four open bays; one of which was designated for paediatric patients. A Clinical Decisions Unit (CDU) had recently been opened (June 2018) which had two fully equipped bedded cubicles; and two cubicles for seated patients.

Between August 2017 to July 2019; the Princess Royal Hospital had a total of 66,838 attendance at Accident and Emergency. This was broken down further to 60,308 attendances at ED and 6,530 at the Urgent Care Centre (UCC).

Between August 2017 and July 2019; 16,164 children (under 18 years) attended the accident and emergency services at the Princess Royal Hospital. 1,912 attended the UCC, and 14,252 attended ED.

During the inspection we spoke with 42 staff members which included doctors, nurses, healthcare assistants (HCAs), specialist nurses, ward administrators, and housekeeping staff. We looked at 11 patient records. We spoke with nine patients about their care; and spoke with 12 relatives/ carers who accompanied patients who attended during our inspection.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

The Emergency Department (ED) at Princess Royal Hospital had not fully addressed breaches of the Health and Social Care Act identified at the last CQC inspection in 2016. These included ensuring the room used for psychiatric patients was compliant with the Mental Health Act requirements, and ensuring the department achieved the Department of Health's (DoH) standard of 95% patients being discharged, admitted or transferred within four hours of arrival.

Urgent and emergency services

Both medical and nurse staffing was not adequate to keep patients safe. The hospital was understaffed; with regular reliance on agency and locum staff. This meant that not all staff were equipped with the specific training and competencies to support patients; particularly overnight when staffing numbers were reduced. In addition, there was not an adequate provision of paediatric trained nurses as per national guidelines.

We found that infection prevention and control practices to be variable; particularly with regards to hand hygiene. In addition, aspects of the ED environment did not support safe care.

Both medical and nursing staff had not achieved mandatory training targets. In addition; safeguarding training levels did not meet the trust target.

Identifying and responding to deteriorating patients was variable. Whilst we observed good practice using nationally validated tools; we also observed cases where deteriorating patients had not been identified or treated in line with national guidance.

We observed staff who were not appropriately trained or competent were co-ordinating the department without local management support during times of staff shortages.

Royal College of Emergency Medicine (RCEM) Audit results for 2016 were poor. However, action plans had been produced and completed in order to improve these.

National targets around patient waiting times in ED were not achieved. For example, the target highlighted above of 95% of patients being discharged, admitted or transferred within four hours of arrival were consistently not achieved.

Complaints were not investigated in line with the trust policy with regards to the length of time to respond.

Morale amongst staff was low; the hospital had a high turnover of nursing staff and a higher sickness rate than the trust target.

The executive team were not consistently sighted on the department in terms of risks and changes. The risk register did reflect concerns we identified during the inspection; and actions were set against each risk. However, many of these risks were actively ongoing and had potential to affect patient safety at the time of our inspection.

Is the service safe?

Inadequate 

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

- Nurse staffing rates had not improved since our previous inspection in 2016 and were not sufficient to manage the department safely during our inspection. Furthermore, there were not enough paediatric trained nurses to safely care for children and young people. There was a high reliance on agency and bank staff and we saw these low staffing levels directly impact on patient's safe care and treatment.
- Due to the high volume of attendances at the department; staff were scheduled as per an escalation rota rather than the actual establishment rota.
- Nursing staff who had not received appropriate support or training had been expected to coordinate the department over the two months before the inspection due to low staffing numbers.
- Middle grade doctors and consultant staffing rates were significantly below nationally recommended figures for an emergency department (ED).

Urgent and emergency services

- The trust did not meet the standard for patients to be seen within one hour of arrival from June 2017 to May 2018. This exposed patients to risk of avoidable harm as they were not receiving timely treatment for their presenting conditions which could include time sensitive conditions.
- Mandatory training compliance levels were very poor for both nursing and medical staff.
- 33% of nursing staff were European Paediatric Life Support (EPLS) trained despite the department being the designated site for paediatric emergencies.
- 35% of medical staff were trained in Paediatric Intermediate Life Support (PILS), 6% trained in EPLS and 18% trained in paediatrics basic life support.
- Although the service had some effective systems in place to recognise and respond to deteriorating patients, risks to patients were not recognised, managed and responded to effectively.
- Sepsis was not always recognised and treated in a timely way. The sepsis pathway was not always followed or correctly completed.
- We looked at 56 sets of patient records and found them all to be inconsistently completed. These included observation charts and National Early Warning Score (NEWS) documentation.
- We were not assured that all staff had the skills and knowledge to identify issues of a safeguarding nature and safeguard children and adults from abuse. Only 37% of nursing staff were trained in safeguarding children level 2.
- There was variable adherence to infection prevention and control measures. This exposed patients and staff to risk of infection and contracting communicable diseases.
- Rooms used for psychiatric patient were still not compliant with the Mental Health Act requirements.
- Aspects of the environment of the Princess Royal Hospital Emergency Department (ED) were not suitable for all patients; in the main this was due to temporary buildings works taking place to build a new urgent care centre.
- Storage within the department was found to be unsafe.
- We were not assured that incidents were reviewed through clinical governance meetings on a regular basis.
- The service prescribed medicines well, however we found medicines were not always stored well.

However:

- We found a positive incident reporting culture within the emergency department (ED) at the Princess Royal Hospital.
- Equipment was maintained and serviced in line with requirements.

Is the service effective?

Requires improvement 

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

- We saw an inconsistent adherence to best practice guidelines around certain medical conditions; notably sepsis and managing deteriorating patients.
- Data provided pre-inspection demonstrated that the Princess Royal Hospital performed poorly in the Royal College of Emergency Medicine (RCEM) 2016 audits.

- Although we observed nutritional and hydrational needs of patients could be met through ordering frozen meals from the catering department, we observed examples of patients with long-term conditions managed inappropriately.
- Regular bank and agency staff could not access support such as relevant competency training or appraisals and supervision.
- We found continued concerns about staff understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments were completed, when required.
- Inductions were not comprehensive for agency staff.

However:

- There was a mechanism to assess patients' pain and we observed this being used well by staff.
- Different teams and specialists from within the hospital supported the care and treatment of patients. This ensured appropriate assessments by the multidisciplinary team.
- Permanent staff undertook yearly competency updates and annual appraisals.

Is the service caring?

Good 

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

- 92.3% of respondents said they would recommend the Emergency Departments (ED) to friends or family as compared to an England average of 87.6%.
- Staff treated patients with dignity and respect during their time in ED.
- Staff were kind and compassionate in their interactions with patients.Staff interacted positively with patients; remaining friendly but professional.
- Emotional support was provided by dedicated staff. Staff engaged positively and maintained an open and caring approach.
- Patients reported they felt involved in their care, and that staff kept them informed as to any treatment plans.
- Patients told us they felt that medical staff explained test results and outcomes well; and that they understood why tests were being undertaken.
- Results from the Emergency Department Survey, conducted October 2016 to March 2017 showed the trust scored about the same as other NHS trusts for questions relating to patient involvement and information provision.

However:

- We identified overnight, ambulatory patients were triaged in the main waiting room which meant they could potentially be overheard by other patients.

Is the service responsive?

Requires improvement  

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

Urgent and emergency services

- Patients could not always access the service when they needed it in a timely way. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- The trust did not meet the standard for review all patients within one hour of arrival from June 2017 to May 2018.
- The percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.
- The number of patients who waited more than 12 hours from the decision to admit to be admitted was not in line with national standards.
- The trust did not respond to complaints in a timely way and in line with their complaints policy.
- Information to advise patients how to complain was limited.
- There was no seating in waiting areas suitable for bariatric patients.

However:

- Compared to the England average, less patients left the department before receiving treatment.
- The Trust had recently opened a Clinical Decisions Unit (CDU) which provided an opportunity to improve the flow of patients from the emergency department.
- Support was available for patients living with dementia and patients with a learning disability or difficulty.

Is the service well-led?

Inadequate 

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

- We were not assured there was sufficient management oversight or capacity and capability to lead the department effectively.
- Communication between local management and senior management teams within the trust was not consistent; and local leaders (senior nurses) were not able to enable significant change despite raising patient safety concerns.
- The local, divisional and executive leadership teams did not assure us they were managing concerns we raised. Several of these were not addressed in a timely manner; and we received contradictory explanations for certain practices within the department.
- Morale was very low amongst nursing staff at the Princess Royal Hospital. This was; in the main; due to staffing problems resulting in additional pressures.
- There was no local strategy or vision at the Princess Royal Hospital. Due to the ongoing Future Fit consultation staff were unsure of the future of the department. Staff reported that updates regarding these potential changes were not consistently provided.
- The pace of improvement for the department was slow. Management of risk, issues and performance was poor. Despite significant concerns being recognised on the trust risk register, substantive actions to reduce risks had not been undertaken.
- The trust did not use a systematic approach to continually improve the quality of its services. Governance was not effective to monitor and manage risks on a regular basis to improve. This placed patients at significant risk of harm.

- Clinical governance meetings were not consistently held and did not promote or enable senior oversight of risk management. We were not assured that learning following these meetings was consistently shared at a local level.
- We saw some examples of poor information governance during our inspection; such as patient identifiable information left in accessible locations.
- We found there was no programme for continuous learning and innovation, beyond the expected training and development for staff.

However:

- Engagement with the public had been ongoing with regards to the future of the trust's emergency department provision.
- Staff were aware of the trust vision and values and fostered a good sense of teamwork. We saw, and staff reported, a good ethos of team work and supporting colleagues. Staff tried their best under extremely challenged circumstances and were hindered in delivering good care by a significant lack of resources and investment.
- We found that on the whole, staff found local leadership supportive and open.

Areas for improvement

The trust must:

- The trust must ensure nurse staffing is adequate to keep all patients safe, including paediatric patients.
- The trust must ensure medical staffing is adequate to keep all patients safe, including paediatric patients.
- The trust must ensure staff receive appropriate mandatory training to undertake their roles in a safe and effective way.
- The trust must ensure rooms allocated for use with psychiatric patients meet requirements to keep patients safe.
- The trust must ensure they enable staff to consistently manage and review deteriorating patients in line with national guidance. The trust should also review their policies regarding managing deteriorating patients.
- The trust must consider how to achieve national key performance indicators in line with the Royal College of Emergency Medicine (RCEM). This includes the 4-hour waiting target.

The trust should:

- The trust should ensure they respond to complaints in an appropriate timescale.
- The trust should consider bariatric facilities in waiting areas.
- The trust should ensure that data protection regulations are adhered to.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Medical care is provided on both the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital Sites. Services provided on the PRH (Telford) site include: Hyper/Acute Stroke and Stroke Rehab (including 24/7 thrombolysis) - single site service accepting strokes from Shropshire, Telford & Wrekin and Powys, Frail and Complex (Care of the Elderly), Respiratory, Nephrology (including Renal Dialysis unit), Cardiology, inpatient Neurology service with all specialities holding clinics in the Outpatients department. In addition, a Falls Prevention and screening service is delivered from the Paul Brown Building. There is a dedicated cardiac catheter laboratory where invasive diagnostic cardiac catheterisation, complex device (i.e. implantable cardiac defibrillator and cardiac resynchronisation therapy) and bradycardia-pacemaker implantations are undertaken supported by a dedicated cardiology day-case unit.

The trust had 69,959 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 27,113 (38.7%), 578 (0.8%) were elective, and the remaining 42,268 (60.4%) were day case.

Princess Royal Hospital has 219 medical inpatient beds located across 18 wards and units. We inspected 10 of these wards and units which included the; acute medical assessment unit, acute medical/short stay ward, cardiology and coronary care unit, respiratory, frail and complex care, gastroenterology, acute and hyper acute stroke unit, stroke rehabilitation, endoscopy and the discharge lounge. We also looked at how inpatient therapies were delivered across these wards and units.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. On our inspection we spoke with 48 members of staff including; registered nurses, healthcare assistants, allied healthcare professionals, domestic staff, matrons and ward managers. We also spoke with 23 patients and five visiting relatives.

The care quality commission last inspected the service in December 2016 and rated the service as good overall. Safe was rated as requires improvement and effective, caring, responsive and well led were rated as good.

Summary of this service

Our rating of this service went down. We rated all five domains as requires improvement because:

- The service had suitable premises with the exception of the areas on wards used for escalation at times of high operational pressures and the discharge lounge environment. At times of high operational pressures patients were not always assessed and treated in a safe and suitable environment.
- The trust did not always plan and provide services in a way that met the needs of local people. A significant number of patients were 'boarded' on wards during periods of high capacity and demand and seven-day rehabilitation was not available for stroke survivors.
- The trust's approach to boarding, handovers and managing patient information meant patients' dignity was not always promoted.
- We saw that one person which the ability to make decisions about their care was unlawfully detained on a ward.
- The service did not have sufficient numbers of permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse.
- The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

Medical care (including older people's care)

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received safeguarding training on how to recognise and report abuse.
- The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents appropriately. Managers investigated incidents and made recommendations. However, effective action to prevent future incidents was not always taken.
- Patient records did not always contain the information required to enable staff to provide safe and consistent care. Medical records were not always stored securely.
- The service did not always take into account the individual needs of patients. Person centred care plans were not devised to plan for patients' individual needs.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. However, the risks associated with malnutrition and dehydration were not always assessed and planned for effectively.
- Compassionate care was not always delivered in a consistent manner as some staff were observed to be task focussed at times, meaning they did not always have the time to consistently treat people in a compassionate manner.
- Medical services had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, staff working on the wards and units we visited reported a disconnect between them and the senior management team and board.
- The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, timely and effective action was not always taken to mitigate risk.
- The service was continuing to work towards seven-day services although yet to achieve it.

However:

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- An effective early warning system was in place to identify deteriorating patients and appropriate action was taken in response to this.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- On the whole pain relief on wards was well managed.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Most staff involved patients and those close to them in decisions about their care and treatment. Most patients felt that staff communicated with them in a way which they could understand their care, treatment and condition.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Medical care (including older people's care)

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- Patient records did not always contain the information required to enable staff to provide safe and consistent care. Medical records were not always stored securely.
- The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received safeguarding training on how to recognise and report abuse.
- The service did not have sufficient numbers of permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse.
- The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents appropriately. Managers investigated incidents and made recommendations. However, effective action to prevent future incidents was not always taken.
- The service did not always have had suitable premises to manage under pressure this included the discharge lounge.
- Some equipment was not readily available for use to meet patient needs.
- Systems were in place to assess and monitor patient risk. However, these systems were not consistently followed to promote patient safety.

However:

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- An effective early warning system was in place to identify deteriorating patients and appropriate action was taken in response to this.
- The service mostly prescribed, gave, recorded and stored medicines well. Patients mostly received the right medication at the right dose at the right time.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Is the service effective?

Requires improvement ↓

Medical care (including older people's care)

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

- We saw that one person which the ability to make decisions about their care was unlawfully detained on a ward.
- The service had systems in place to ensure that care and treatment was based on national guidance and evidence of its effectiveness. However, this was not always effective as treatment related policies and guidance were not always reviewed in a timely manner. This meant that we could not be assured that treatment policies and guidance were based on the most up to date evidence.
- Outcomes for people who use services were below expectations compared with similar services. The service did not meet many of the national aspirational standards in the Sentinel Stroke National Audit programme. Results from the National Audit of Inpatient falls also showed that the trust performed significantly worse in some metrics than the national average in the 2017.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. However, the risks associated with malnutrition and dehydration were not always assessed and planned for effectively.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. However, effective action was not always taken in response to poor audit results to drive improvement.
- Systems were in place to ensure staff were competent for their roles. Managers appraised staff's work performance and completed competency assessments as required. However, supervision meetings with staff to provide support and monitor the effectiveness of the service were not completed consistently in all areas.
- The service was continuing to work towards seven-day services although yet to achieve it.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- On the whole pain relief on wards was well managed.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.

Is the service caring?

Requires improvement 

Our rating of caring went down. We rated it as requires improvement because:

- Compassionate care was not always delivered in a consistent manner as some staff were observed to be task focussed at times, meaning they did not always have the time to consistently treat people in a compassionate manner.
- The trust's approach to boarding, handovers and managing patient information meant patients' dignity was not always promoted.
- There was an inconsistent approach to the provision of emotional support. Some staff did this better than other staff.

Medical care (including older people's care)

However:

- Most staff involved patients and those close to them in decisions about their care and treatment. Most patients felt that staff communicated with them in a way which they could understand their care, treatment and condition.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- The trust did not always plan and provide services in a way that met the needs of local people. A significant number of patients were 'boarded' on wards during periods of high capacity and demand and seven-day rehabilitation was not available for stroke survivors.
- People could not always access the right services when they needed it. There were consistently high numbers of medical patients who were not accommodated on the medical speciality wards they required. These patients were known as 'medical outliers'.
- The service did not always take into account the individual needs of patients. Person centred care plans were not devised to plan for patients' individual needs.
- The number of times patients were moved beds for non-clinical reasons was not monitored. Therefore, the trust did not have the information needed to monitor and improve this part of patient care.

However:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Waiting times for treatment and arrangements to treat and discharge patients were mostly in line with good practice.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Medical services had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, staff working on the wards and units we visited reported a disconnect between them and the senior management team and board.
- The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, timely and effective action was not always taken to mitigate risk.
- Staff told us that managers across the medical service promoted a positive culture that supported staff and created a sense of common purpose. However, some of our observations recorded under caring showed that a positive culture based on shared, caring values was not always demonstrated.
- The trust did not always use a systematic approach to continually improve the quality of its services or safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

- The trust was not always committed to improving services by learning from when things go well and when they go wrong, promoting research and innovation.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Areas for improvement

The trust must:

- Ensure that patients individual needs are assessed and planned for. This includes needs that are related to any learning disabilities, pressure care, nutrition and hydration and end of life care needs.
- Ensure that all patients are consistently treated with dignity and respect.
- Ensure that during periods of increased demand and capacity safe systems are in place to manage this.
- Ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm.
- Ensure that effective systems are in place to reduce the risk of safety incidents from reoccurring.
- Ensure that sufficient permanent staff are employed to keep people safe from avoidable harm and abuse.
- Ensure staff complete mandatory training in line with the trust targets.
- Ensure that no patients are unlawfully detained at the hospital.

The trust should:

- To continue progress towards implementing a sustainable seven-day service.

Surgery

Requires improvement 

Key facts and figures

Surgery services provided by Shrewsbury and Telford NHS trust are located on two hospital sites which provide both elective and emergency surgery to the population of Shrewsbury, Telford, Wrekin and the wider areas.

Royal Shrewsbury Hospital, Shrewsbury and The Princess Royal Hospital, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the scheduled care group across both hospitals with the same clinical directors. For this reason, there may be some duplication contained within the two evidence appendices.

The trust has 19 operating theatres and 224 surgical inpatient beds across eight surgical wards and units. All patients admitted were treated under the direct care of a consultant. A senior house officer supported surgical care 24 hours a day, seven days a week. Patients are cared for and supported by registered nurses, care assistants and allied health professionals.

This summary relates to surgery services provided at Royal Princess Hospital, Telford, which provides both elective and emergency surgery.

We inspected the service from 21 to 23 August 2018 and on 7 September 2018. As part of the inspection we visited the following areas:

- Surgery pre-assessment clinic
- Surgical assessment lounge
- Day surgery unit
- Day surgery theatres and main theatres
- Recovery area
- Wards 4 (orthopaedic) and 17 (head and neck and trauma and orthopaedic)

Trust wide data is included within this surgery core service report for comparison with the core service data. Please refer to the provider level report for further information.

The trust had 31,041 surgical admissions from February 2017 to January 2018. Emergency admissions accounted for 12,104 (39%), 15,362 (50%) were day case, and the remaining 3,575 (12%) were elective.

During the inspection visit, we spoke with 10 patients and their families. Reviewed 14 patient records and trust policies. Reviewed performance information and data from, and about the trust. Obtained patient feedback and observed their care. We spoke with 20 members of staff including doctors, managers, nurses, housekeepers, chaplaincy staff and other allied health professionals. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the hospital.

The service was last inspected in December 2016. At the last inspection, it was rated as requires improvement overall including safe, responsive and well led. It was rated as good for effective and caring. We looked at the changes surgical services had made to improve the service during this inspection.

Surgery

Summary of this service

Our overall rating stayed the same. We rated it as requires improvement because:

- Managers investigated incidents but there were no clear procedures in place to share lessons learned with the whole team and the wider service.
- The service provided mandatory training in key skills but did not ensure all nursing and medical staff completed it. However, there was an action plan in place to address this.
- The service had enough staff with the right qualifications and skills but not all staff had completed training in sepsis management.
- The service monitored the effectiveness of care and treatment but did not consistently use the findings to improve patient outcomes.
- Records were not always stored appropriately or securely to maintain patient confidentiality.
- The service did not present an embedded consistent systematic approach to continually monitor the quality of its services.
- The service controlled infections but not all staff followed the trust's infection prevention and control guidance to ensure patients were kept safe from the spread of infection.
- Most staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Although staff generally understood their roles and responsibilities under the Mental Health Act 1983 and the MCA.
- Staff informed us senior executives were not visible and there was poor engagement with surgical staff.
- The tracheostomy pathway had been developed but the policy remained on the trust intranet page in draft form dated 2014.
- We saw additional policies that were out of date or not ratified on the trust intranet page for staff to access.

However:

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Senior staff across the service promoted a positive culture that supported and valued staff, based on shared values.
- The trust generally planned and provided services in a way that met the needs of local people.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Pain was managed effectively and staff provided or offered pain relief regularly.
- Staff provided patients with enough food and drink to meet their needs and improve their health.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- All clinical staff we spoke with demonstrated a good understanding and knowledge of the principles of patient consent.

Surgery

- Nursing staff used national early warning scores (NEWS) to assess and monitor a patient's condition electronically and in paper format.
- Lessons learned from complaints were shared with all staff members effectively.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Patient feedback was positive about care and compassion, they felt safe.
- Staff offered emotional support to relieve patient anxiety.
- Staff had good knowledge to raise safeguarding alerts.
- Staff were knowledgeable about escalation of deteriorating patients.
- Agency staff received a trust induction and ward based competencies.
- There was good pastoral care.
- Staff were knowledgeable about how to support patients with complex needs such as dementia or a learning disability

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff completion data for mandatory training did not meet the trust targets.
- There was no data available for adult safeguarding training for medical staff.
- We were not assured of the World Health Organisation (WHO) safer surgery guidance compliance with the sign in process.
- Theatre controlled drug checks were observed as not completed daily and staff reported anaesthetics who discarded controlled drug waste without a witness present.
- The service reported two incidents classified as a never event for surgery. A root cause analysis was completed following both serious incidents that occurred. Senior staff said they had not received feedback.
- Ward and theatre areas were visibly clean although cluttered with patient equipment and visitor chairs in front of fire exists.
- The reported case of clostridium difficile within scheduled care identified a delay in isolation.
- There were inconsistent infection and prevention practices across the service. A patient in isolation had the side room door left open on two separate days.
- Staff were observed not adhering to infection prevention and control guidance regarding protective personal equipment.
- Records were not stored securely to maintain patient confidentiality.
- Equipment was visibly clean, but not all equipment was consistently labelled to confirm recent cleaning.

- Resuscitation equipment was available on the ward and in theatre. Records showed that the equipment had been visually checked daily. A weekly comprehensive check was performed, with the seal on the trolley being broken and replaced to check the contents. The tag label was not numbered so no audit trail could be confirmed.
- The service mostly controlled infections risk well. However, not all nursing and medical staff used appropriate control measures to prevent the spread of infection.
- Staff kept appropriate records of patients' care and treatment. However, not all records were kept in locked trolleys to maintain confidentiality.

However:

- Theatre access was secure, with a reception area where staff were greeted and shown to changing areas. The storage of surgical equipment and instruments was well organised with appropriate stock levels maintained.
- Medical staffing for surgery was provided with suitable arrangements for on call and out of hours support.
- The National Early Warning System (NEWS) was used electronically and in paper form and staff were competent in identifying and responding appropriately to a deteriorating patient for medical emergencies.
- Ward based safer staffing levels were adhered to with the use of bank and agency staff. Staffing levels were displayed across all areas.
- Patient moving and handling equipment was available on the ward and in theatres. This had been maintained and serviced appropriately, maintenance records were seen.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Patients told us they received their analgesia in a timely way and the effectiveness was monitored.
- The safety thermometer was recorded and displayed on all ward areas.
- Theatres were staffed as per The Association for Perioperative Practice (AfPP) recommendations for safer staffing. AfPP aims to enhance the quality of care and patient safety in the NHS and the independent sector throughout the UK.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service provided care and treatment based on national guidance but not all policies were found on the intranet page.
- We did not see the management of medicines policy on the trust intranet Page for staff.
- Health promotion leaflets were available in public and ward areas for patients and visitors to read. We saw photocopies of patient information leaflets with no date or author included. Leaflets did not include whether they were available in another language.
- Staff told us that national and local safety standards for invasive procedures (Natssip/Locssip) were not fully standardised or harmonized across the organisation. This would assist in monitoring the provision of safer care and can reduce the number of patient safety incidents related to invasive procedures in which surgical never events occur.

Surgery

- Theatre staff told us that the audit process was not embedded.
- Trauma and orthopaedics patients at The Princess Royal Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Ear, nose and throat (ENT) and urology patients at The Princess Royal Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- The service was an outlier for fracture neck of femur as it was not meeting the 36-hour target due to lack of capacity within the trauma list. The action plans submitted showed extra weekend trauma lists would commence to reduce delays. However, we could not be assured this issue was addressed as no completed action was submitted to prevent reoccurrence.

However:

- Relevant and current evidence-based guidance was followed as care standards, best practice and legislation was identified and used to develop the delivery of services, care and treatment.
- Some ward based link nurses were identified for specific areas such as infection control, and sepsis.
- From March 2017 to February 2018, overall, patients at The Princess Royal Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- From September 2017 to August 2018 98.4% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- All clinical staff we spoke with demonstrated a good understanding and knowledge of the principles of patient consent.

Is the service caring?

Good  

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

- The Friends and Family test response rate for surgery was 35% which was better than the England average of 29% from April 2017 to March 2018.
- We observed staff care for patients with compassion. Feedback from all patients we spoke with confirmed that staff treated them well and with kindness.
- We observed staff interact with patients and visitors. We saw that staff were friendly and gave the patients suitable time to support them.
- We observed that call bells were answered promptly and staff were attentive when talking with patients.
- Staff protected patient's dignity by using curtains and screens appropriately.
- We observed that staff involved patients and those close to them in decisions about their care and treatment. Patients we spoke with told us that they fully understood their treatment and were aware of their aftercare plan and potential discharge date.

Surgery

- Staff provided emotional support to patients to minimise their distress peri-operatively. Patients told us that the staff had been very sensitive to their individual needs and had supported them.
- The chaplaincy team had a chapel situated one the first floor of the hospital which was open 24 hours a day for prayer or a place to be quiet. The denomination of minister taking the service varied, but all were welcome to attend. The pebble pool and pray system supported those who would have lit a candle in memory of a loved one.

Is the service responsive?

Requires improvement 

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

- Complaint handling was not always managed appropriately, executives did not always sign off responses.
- Surgical wards during the winter months were often full with medical outliers.
- There was no submitted data for trauma and orthopaedics referral to treatment time (RTT).
- The submitted theatre safety action plan had no completed actions identified.

However:

- Carers and family members were actively encouraged to attend the hospital and be involved in the care and support of their relative. This included helping at meal times if necessary and supporting them emotionally.
- We observed discharge information and advice was provided which included specific advice.
- Patients with a learning disability or needs that required assistance were supported by staff through the admission process.
- The percentage of cancelled operations at the trust showed a similar trend to the England average.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Staff told us that the surgical managers and clinicians did not have a good working relationship.
- Staff described a positive local leadership culture and felt supported by their immediate managers who were visible in the departments but described no visible leadership and poor role modelling behaviour from the executives.
- During our inspection, we found areas of concern that were highlighted in our December 2016 inspection that had not all been addressed. For example, there were inconsistencies with infection control and we observed protective personal equipment that was not used correctly.
- Staff told us how they had not received appropriate feedback from never events to improve services by learning from when things go well and when they go wrong.
- Staff told us they had ward meetings which were not regular monthly meetings, this area was highlighted at the previous inspection.
- Infection prevention and control trust wide monthly meetings at PRH were cancelled five times in 2017.

- Theatre risk register evidenced a risk for more than two years that remained unresolved.

However,

- The trust had a vision for what it wanted to achieve. Staff were familiar with the headlines of the vision.
- There was a Governance framework and quality performance structure in place within this service.

Areas for improvement

The trust must:

- All controlled drugs must be checked daily and evidence documented
- The trust must monitor all medical staff are trained to the required level of safeguarding for both adult and children.

The trust should:

- The trust should monitor that all staff complete their mandatory training.
- The trust should monitor staff compliance with the infection control practices across the surgical service.
- The trust should monitor how records are stored safely and confidentially maintained.
- The trust should continue to work to improve the admitted referral to treatment time.
- The trust should review the complaint handling process.

Critical care

Requires improvement 

Key facts and figures

We inspected the critical care service as part of the new phase of our inspection methodology. The inspection of the service was unannounced.

We inspected the critical care unit at Princess Royal Hospital. The trust has another critical care unit at Royal Shrewsbury Hospital but information about this service is included in the Royal Shrewsbury Hospital location report.

The critical care unit at Princess Royal Hospital provides a service to patients who need intensive care (described as level three) or high dependency care (described as level two). Patients are admitted following complex and/or serious operations and in the event of medical and surgical emergencies. There had been 462 admissions to the intensive care unit between April 2017 and June 2018, of which 334 were non-surgical admissions.

The unit provides support for all inpatient specialities within the acute hospital and to the emergency department. A consultant intensivist (a consultant specialising in intensive care medicine) leads the service with support from the consultant team, junior doctors, and a team of nurses and support staff. The unit has 11 bed spaces, used flexibly and funded by commissioners to provide care to six level three patients.

The unit is divided into two discrete areas, one area was used for critical care patients (level three) and the other for high dependency patients (level two). The critical care area of the unit has five bed spaces, including two side rooms and the high dependency area has six bed spaces. There were two nurses' stations, one for each area of the unit.

During the inspection visit, the inspection team:

- Spoke with one patient and three relatives;
- Observed staff giving care to five patients;
- Reviewed four patient records;
- Reviewed trust policies;
- Reviewed performance information and data about the trust;
- Obtained patient feedback;
- Spoke with 19 members of staff at different grades from band three to band eight including nurses, physiotherapists, pharmacists, doctors, consultants, administration and housekeeping;
- Met with service leads, professional leads and team managers.

The Care Quality Commission last inspected the service in October 2014 and rated the critical care as requires improvement overall with safe, effective, responsive and well led rated as requires improvement. The critical care service was issued with two requirement notices and seven recommendations for service improvement in the safe, effective, responsive and well led domains. During our inspection, we looked at changes the critical care service had made to address these concerns.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

Critical care

- Mandatory training compliance levels for medical staff were significantly lower than the trust's target.
- Medical staffing levels had not improved since our previous inspection and so were not in line with the required standards which meant that people did not always receive safe care and treatment or experience continuity of care in relation to medical personnel.
- Arrangements for the ward round did not always include multidisciplinary input.
- Recommended guidelines relating to allied health professional staffing levels were not met.
- The critical care outreach service did not operate 24 hours a day.
- The hospital at night team did not always ensure a safe service.
- Delivery of people's care, treatment and support was not always in line with legislation, standards and evidence based guidance.
- The rehabilitation needs of patients were not always addressed which could lead to less favourable outcomes.
- The collection and monitoring of information about the outcomes of people's care and treatment was limited.
- Participation in quality improvement initiatives was limited and there was little evidence relating to benchmarking, accreditation schemes, peer review, research or trials.
- There was limited evidence relating to participation in a comprehensive programme of clinical audit which specifically related to critical care.
- Less than 50% of nursing staff had achieved their post registration qualification in critical care nursing.
- Services were not always available to patients seven days a week.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty training was extremely low.
- The service did not always identify how it could be developed or improved when patient needs were not addressed.
- Timely access to initial assessment, test results, diagnosis and treatment was not always possible.
- Discharge from the critical care unit was not always in accordance with national standards and did not always take place at appropriate times or place.
- Patient diaries were not in use on the unit.
- Patients did not have access to formal counselling services for patients.
- Managers had the right skills and abilities to provide the service but there was lack of overarching managerial arrangements to ensure a coordinated critical care service across both the trust's hospitals to provide a safe, high-quality and sustainable care.
- The challenges to quality and sustainability were known to leaders but the actions needed to address them were not being implemented promptly.
- There was a lack of clinical leadership and it was unclear as to whether there were priorities for ensuring sustainable and effective leadership within the critical care unit.
- Limited action was being taken to improve the service and there did not appear to be an immediate vision for the critical care unit.
- The long-term vision and strategy was known to staff but it was unclear as to whether they had collaborated with leadership in shaping them.

Critical care

- Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were unclear.
- Governance and management systems were not functioning effectively or interacting with each other appropriately.
- It was unclear whether there were comprehensive assurance systems or whether performance issues were escalated appropriately through clear structures and processes.
- There were not always clear and robust service performance measures which were always reported and monitored.
- The service's approach to service delivery and improvement was inconsistent.

However;

- Regular updates and training in the systems and processes were provided to staff which helped to keep people safe and Mandatory training compliance was in line with trust targets.
- People were protected from abuse, neglect, harassment and breaches of their dignity and respect due to the services safety and safeguarding systems.
- The service maintained high standards of cleanliness and hygiene.
- The premises and facilities of the critical care unit were generally designed, maintained and used to keep people safe.
- Maintenance and use of equipped appeared safe.
- Risk assessments carried out on people who used services were comprehensive.
- The planning and review of nursing staffing and skill mix usually ensured people received safe care and treatment.
- People's individual care records, including clinical data, were written and managed in a way that kept people safe.
- Medicine management arrangements kept people safe as they were recorded, administered and stored appropriately.
- There was a low number of serious incidents.
- Prevalence of patient harm was recorded using the Safety Thermometer and it was also used to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- Physical, mental health and social needs of patients were holistically assessed.
- Good patient outcomes in relation to mortality and unplanned readmissions to the unit were being achieved.
- The National Organ Donation programme was in operation within the trust.
- Nutrition and hydration needs were identified, monitored and met.
- Pain was effectively assessed and managed.
- The critical care unit was involved in the local critical care network.
- The assessment, planning and delivery of care involved necessary staff, including those in different teams, services and organisations.
- The relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, was understood by staff.
- The personal, cultural, social and religious needs of patients were understood and respected by staff and were considered when delivering care.
- Staff took time to interact with patients and those close to them, in a respectful and considerate manner.

Critical care

- Patients' privacy and dignity was always respected, including during physical and intimate care.
- Patient confidentiality was respected by ensuring conversations took place in private or when at the bedside.
- Care, treatment and condition was understood by patients.
- The impact a patient's care, treatment and condition had on their wellbeing and on those close to them was understood by staff.
- Carers were treated as important partners in the delivery of patient care.
- A sensitive approach to relatives was taken when a patient might be a possible eligible organ donor.
- Patients' health needs could be addressed on the unit as appropriate equipment was available.
- Services were delivered, made accessible and coordinated to take account of the needs of different people.
- Some action was being taken to minimise the length of time people had to wait for care, treatment and advice.
- Complaints were handled effectively and confidentially, with regular updates provided and a formal record being kept.
- Local leaders were visible and approachable.
- The trust had a clear set of values, with quality and sustainability as the top priorities.
- Staff felt supported, respected, valued and proud to work in the organisation.
- Arrangements for identifying and recording risks were in place and there was an alignment between recorded risks and what staff say is on their worry list.
- The service gathered people's views and experiences to shape and improve the service and culture.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Mandatory training compliance levels for medical staff were significantly below the trust's target.
- Medical staffing levels were not in line with the required standards which meant that people did not always receive safe care and treatment as there was limited consultants in intensive care medicine availability. This was an issue during our previous inspection.
- Patients did not experience continuity of care in relation to medical personnel as they were treated by different consultants across the week.
- Band six nurse charge nurses were not always supernumerary during a shift and would regularly take over the care of level two and three patients, if staffing levels on the unit were low.
- Arrangements for the ward round were not in line with the required standards as they lacked consistent multidisciplinary input.
- Allied health professional staffing levels were significantly below the recommended guidelines as there was insufficient pharmacy, physiotherapy, dietician, speech and language, occupational therapy cover.
- Compliance with safeguarding training for staff was significantly below the trust target.

Critical care

- The unit had not audited themselves against the Health Building Note on critical care units and so were unaware of areas of non-compliance.
- Cover from the critical care outreach team was limited as it only operated between 8am and 8pm.
- The hospital at night team could not always ensure a safe service was delivered every night of the week as a result of poor staffing.
- There were no formal mortality and morbidity meetings.

However:

- The service provided training and regular updates in the systems and processes which helped to keep people safe and compliance with mandatory training was in line with trust targets.
- Safety and safeguarding systems, processes and practices protected people from abuse, neglect, harassment and breaches of their dignity and respect.
- High standards of cleanliness and hygiene were maintained.
- Infection rates on the unit were lower than the national average.
- In general, the premises and facilities of the critical care unit were designed, maintained and used to keep people safe.
- Equipment was maintained and used safely.
- Comprehensive risk assessments were carried out for people who use services.
- Nurse staffing and skill mix were planned and reviewed which usually ensured people received safe care and treatment.
- People's individual care records, including clinical data, were written and managed in a way that kept people safe.
- Arrangements for managing medicines kept people safe as they were administered and stored appropriately.
- The service had a good track record on safety as there was a low number of serious incidents.
- The Safety Thermometer was used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- People's care, treatment and support was not always delivered in line with legislation, standards and evidence based guidance.
- Patient rehabilitation needs were not always addressed which could lead to them achieving less favourable outcomes.
- All staff had access to trust policies and procedures but they were not always up to date.
- Limited information about the outcomes of people's care and treatment was routinely collected and monitored.

Critical care

- There was minimal participation in quality improvement initiatives, with limited involvement in benchmarking, accreditation schemes, peer review, research or trials.
- It was unclear whether there was participation in a comprehensive programme of clinical audit which specifically related to critical care.
- It was not always possible for the service to ensure staff had the right qualifications to deliver effective care, support and treatment as less than 50% of staff had achieved their post registration qualification in critical care.
- Staff did not receive formal monthly/six weekly one-to-one meetings or clinical supervision.
- Care was not always delivered and reviewed in a coordinated way when different teams, services or organisations were involved as there were separate handovers for nurses and doctors and severely limited multidisciplinary daily ward round.
- High quality services were not always available seven days a week.
- Compliance with Mental Capacity Act (MCA) and Deprivation of Liberty training was extremely low.

However:

- People's physical, mental health and social needs were holistically assessed.
- The unit were achieving good patient outcomes in relation to mortality and unplanned readmissions to the unit.
- The trust was part of the National Organ Donation programme.
- People's nutrition and hydration needs were identified, monitored and met.
- Patients' pain was effectively assessed and managed.
- The unit was part of the local critical care network.
- The learning needs of all staff were identified.
- Necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Is the service caring?

Good 

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

- Patients personal, cultural, social and religious needs were understood and respected by staff and were considered when delivering care.
- Time was taken to interact with patients and those close to them in a respectful and considerate manner.
- Staff ensured patients' privacy and dignity was always respected, including during physical and intimate care.
- Confidentiality was respected by ensuring conversations about patient care took place in private or when at the bedside.
- Patients understood their care, treatment and condition.

Critical care

- Staff understood the impact a patient's care, treatment and condition had on their wellbeing and on those close to them.
- People's carers were treated as important partners in the delivery of their care.
- There was a sensitive approach to relatives when a patient might be a possible eligible organ donor.

Is the service responsive?

Requires improvement 

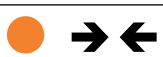
Our rating of responsive stayed the same. We rated it as requires improvement because:

- Facilities on the unit were not always ideal for patient orientation.
- Where people's needs and choices were not being met, the service did not always identify how it could be developed or improved. For example, the lack of follow-up clinics for discharged patients.
- The service identified but could not always meet the information and communication needs of people with a disability and sensory loss.
- People did not always have timely access to initial assessment, test results, diagnosis and treatment.
- Patients were not always discharged from the critical care unit in accordance with national standards.
- Discharges from the critical care unit did not always take place at appropriate times or place.
- The unit was not always able to accommodate patients in single sex areas.
- There were no formal arrangements for counselling services for patients.
- The unit was not using patient diaries which meant there was no provision to fill in gaps in patient memory.

However:

- Appropriate equipment was available which meant patients' health needs could be addressed on the unit.
- Translation services were available to assist communication with patients who did not speak English but access to written materials in other languages was limited.
- Services were delivered, made accessible and coordinated to take account of the needs of different people.
- Some action was being taken to minimise the length of time people had to wait for care, treatment and advice.
- Complaints were handled effectively and confidentially, with regular updates provided and a formal record being kept.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Managers had the right skills and abilities to provide the service but there was lack of overarching managerial arrangements to ensure a coordinated critical care service across both the trust's hospitals to provide a safe, high-quality and sustainable care.

Critical care

- The service did not have a clinical director and this impacted on the overall clinical leadership.
- Leaders understood the challenges to quality and sustainability but the actions needed to address them were not being implemented promptly
- It was unclear as to whether there were clear priorities for ensuring sustainable and effective leadership within the critical care unit as there was a lack of clinical leadership.
- The immediate vision for the critical care unit was unclear with limited action being taken to improve the service.
- The vision and strategy was known to staff operating on the unit but it was not clear whether they had collaborated with leadership in shaping them.
- Morale within the critical care unit was mixed.
- It was unclear if there were structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.
- All levels of governance and management were not functioning effectively or interacting with each other appropriately.
- Governance arrangements on the critical care unit had been implemented but were not yet embedded.
- Some staff were unclear on their roles and they did not always understand what they were accountable for.
- It was unclear whether there were comprehensive assurance systems or whether performance issues were escalated appropriately through clear structures and processes.
- There were not always clear and robust service performance measures which were always reported and monitored.
- The arrangements for ensuring the availability, integrity and confidentiality of identifiable data, records and data management systems, were not always in line with data security standards.
- There was an inconsistent approach to service delivery and improvement.

However:

- Local leaders were visible and approachable.
- The trust had a clear set of values, with quality and sustainability as the top priorities.
- Staff felt supported, respected, valued and proud to work in the organisation.
- There were arrangements for identifying and recording risks and there was an alignment between recorded risks and what staff say is on their worry list.
- People's views and experiences were gathered and acted on to shape and improve the services and culture.

Areas for improvement

The trust must:

- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This relates specifically to consultant in intensive care medicine and allied health professional provision.
- Ensure there are effective systems to assess, monitor and review the performance of the unit so the safety and quality of care provided can be improved.

Critical care

The trust should:

- Ensure mandatory training compliance levels for medical staff are improved to comply with trust targets.
- Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance.
- Ensure monthly mortality and morbidity meetings take place, are recorded and any learning shared with the appropriate parties.
- Ensure all areas of non-compliance with the Department of Health guidelines for critical care facilities (Health Building Note 04-02) are identified and included on the local risk register.
- Ensure the cover provided by the critical care outreach team complies with required standards.
- Ensure the cover provided by the hospital at night team is safe.
- Ensure that appropriate audits are carried out and used to improve the performance of the unit and outcomes for patients.
- Ensure all relevant policies are up to date.
- Ensure that compliance with Mental Capacity Act and Deprivation of Liberty training complies with trust targets.
- Ensure there are adequate counselling arrangements for patients.
- Ensure follow-up clinics are available and offered to suitable patients.
- Ensure access and flow into and out of the critical care unit is improved so patients receive the right care at the right time and in the right place.
- Ensure the risk register in use within the department includes all risks identified by the unit and actions discussed to ensure all relevant parties are kept up to date.
- Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.
- Review the provision of physiotherapy resource to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).
- Ensure the leadership of the critical care unit is effective.

Maternity

Requires improvement

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust provides maternity services at the Princess Royal Hospital, Telford. The maternity services available to women include home birth, a midwifery led unit (MLU), a consultant-led delivery suite, a range of antenatal clinics including ultrasound scanning and fetal medicine, a day assessment unit, triage, one antenatal ward, two postnatal wards one located in the consultant led unit and one located in the MLU. Specialist midwives are available to support the women and midwives. Additional antenatal and maternity led birthing unit services are provided at the Royal Shrewsbury Hospital.

The trust also employs community midwives, who provide care for women and their babies both during the antenatal and postnatal period and provide a home birth service

The community midwives are aligned to the local GP practices.

Our inspection was unannounced in accordance with our new inspection methodology.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings.

During this inspection we:

- Spoke with 28 staff members; including service leads, matrons, midwives, doctors, non-registered and administrative staff.
- Spoke with 12 women who were using the service.
- Checked 12 pieces of equipment.
- Reviewed 15 medical records.
- Reviewed five prescription charts.

Princess Royal Hospital has 53 maternity beds of which 17 are antenatal, 36 are postnatal and they have 13 birthing rooms on the delivery suite and 4 birthing rooms on the Wrekin MLU.

Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement because:

- Staff had not completed mandatory training in accordance with the trust's target.
- Staff had not completed adult safeguarding training in accordance with the trust's target.
- Staff had not completed Cardiotocograph training in accordance with the service's target.
- Community staff did not have all of the equipment needed to do their work in accordance with best practice.

Maternity

- Maternity Early Obstetric Warning Score (MEOWS) were not always fully completed.
- High risk women in labour were not always reviewed regularly and by the appropriate member of staff.
- The SBAR (situation, background, assessment, recommendation) forms were not always fully completed when midwives handed over care.
- Prescription and observation charts were not stored confidentially they were left unattended at the midwives' desk on the ward area.
- The service did not meet national guidance for the number of anaesthetists recommended by the Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland 2013 guidelines for obstetric anaesthesia.
- Outcomes on the maternity dashboard were not clearly colour coded and we did not observe this on meeting minutes as a standing item for MDT discussion.
- Midwives were not aware of the service plan to implement a new process to replace statutory supervision of midwives which ceased in April 2017.
- Women were not receiving carbon monoxide screening in line with national guidance.
- Staff told us that leaflets were accessible to print off but were limited in alternative languages or easy read versions.
- There were no displays to inform people how to complain to the service and women we spoke to did not know how to complain.
- Not all women were booked before ten weeks of pregnancy, the service did not meet the trust target.
- Staff were not able to describe any complaint the service had received of if the service had any changes in practice following a complaint.
- The head of midwifery did not have direct access to the board.
- Action plans developed following external reviews were not fully embedded in practice.
- The executive team were not visible and staff did not feel supported by them in challenging times.
- There was a lack of defined strategy for the service and staff did not know the vision for their service.
- Staff were not able to explain what happened to risks and concerns shared at governance meetings and felt that they escalated concerns, but did not see actions or feedback responses from the executive leadership team.
- Not all risks we encountered during the inspection were added to the maternity risk register. For example, the number of women booked before ten weeks of pregnancy was poor. This had not been identified as a risk by the service.
- Staff described not being actively involved or engaged in changes within the service, with decisions made at care group level without their involvement.
- Staff were not able to give examples of new initiatives within the unit, although staff were committed to making improvements for women and babies.
- The maternity staff survey results showed a decline from 2015 to 2017, with regard to recommending the trust as a place to work and the extent staff were motivated and engaged in their work.

However:

- Staff had completed children safeguarding training in line with the trust's target.

Maternity

- The service reported patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Resuscitation equipment was checked and recorded daily in all areas.
- Staff could describe their responsibilities regarding the duty of candour (DoC) regulation and when this needed to be implemented.
- Care and treatment was in the main managed in accordance with national guidance.
- Antenatal screening for blood born infections was offered to women and the service was compliant with national key performance indicators.
- Staff with different roles worked together as a team to provide holistic care to women. We observed that staff were respectful of one another and all staff we spoke with said that they worked well together as a team.
- The service provided seven-day services to women to enable them to be seen when they needed to access care and/or advice.
- Staff understood and respected the personal, cultural, social and religious needs of women and those important to them.
- All women we spoke with within the unit told us that their confidentiality, privacy and dignity was maintained.
- Bereavement services and staff knowledge on supporting bereaved families ensured people received the care physical and emotional care required.
- Although some services were closed the service continued to provide choice for women. There were a range of clinics and high and low risk services at the unit.
- The service provided a range of specialist clinics and specialist midwives to meet the needs of women using the service.
- Medical staff without exception felt supported by their managers and were complimentary regarding the experiences and training they received.
- There were good working relationships between the senior leadership team of the maternity service and the managers of the departments.
- The trust had appointed a maternity safety champion, in line with national recommendations (Department of Health 'Safer Maternity Care: Next steps towards the national maternity ambition', October 2016). They were the director of nursing, midwifery and quality and the medical director.

Is the service safe?

Inadequate

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as inadequate because:

- Staff had not completed mandatory training in accordance with the trust's target.
- Staff had not completed adult safeguarding training in accordance with the trust's target.
- Staff had not completed Cardiotocograph training in accordance with the service's target.

Maternity

- There was poor evidence of learning from serious incidents. Staff could not give examples of learning.
- Midwives were acting as scrub practitioners for emergency caesarean sections, which removed them from midwifery specific duties depleting the staffing levels further.
- The trust's lone working policy was not adhered to, putting staff members at risk.
- The process to identify which equipment had been cleaned was not consistent.
- The maternity led unit did not comply with the Department of Heath recommendations 2013, only one of the four birthing rooms on the midwifery led unit had en-suite facilities.
- Equipment was not always safety checked in line with safety standards.
- Community staff did not have all of the equipment needed to do their work in accordance with best practice.
- Maternity Early Obstetric Warning Score (MEOWS) were not always fully completed.
- High risk women in labour were not always reviewed regularly and by the appropriate member of staff.
- The SBAR (situation, background, assessment, recommendation) forms were not always fully completed when midwives handed over care.
- One to one care of the women in established labour was consistently not achieved.
- The ward did not have a dedicated Transitional care unit (babies who require enhanced care). Midwives cared for these babies which increased their workload.
- Prescription and observation charts were not stored confidentially, they were left unattended at the midwives' desk on the ward area.
- Prescription charts were not always completed, the woman's weight was not always recorded.
- Medicines were not always prescribed in line with the antibiotic formulary.
- Not all low harm/near miss incidents were closed in a timely manner.
- Incidents were not always graded correctly. We reviewed some that were graded as no or low harm which did not reflect the level of harm to the woman or baby.
- The service did not meet national guidance for the number of anaesthetists recommended by the Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland 2013 guidelines for obstetric anaesthesia.

However:

- Staff had completed children safeguarding training in line with the trust's target.
- Hand hygiene audits were displayed and compliant with trust targets.
- Staff kept appropriate records of women's care and treatment. Handheld and medical records were clear, up-to-date and available to all staff providing care. Completion of cardiotocography trace records was in line with trust policy.
- The service reported patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Resuscitation equipment was checked and recorded daily in all areas.
- Staff could describe their responsibilities regarding the duty of candour (DoC) regulation and when this needed to be implemented.

Maternity

Is the service effective?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement because:

- Care and treatment did not always reflect current national guidance standards. For example, high risk women did not always have regular medical reviews when in labour.
- The service was not auditing the time women requested an epidural to the time they received one in accordance with NICE guidance, CG70 Induction of labour, July 2014.
- Outcomes on the maternity dashboard were not clearly colour coded and we did not observe this on meeting minutes as a standing item for MDT discussion.
- The outcomes of care and treatment were not monitored robustly, we reviewed three meetings with no medical staff in attendance.
- Midwives were not aware of the service plan to implement a new process to replace statutory supervision of midwives which ceased in April 2017.
- Women were not receiving carbon monoxide screening regularly in line with national guidance.

However:

Staff assessed women's nutrition and hydration needs appropriately and the maternity service promoted healthier feeding practices and UNICEF Baby Friendly Initiative standards of feeding for all babies.

- Women could have a choice of pain relief and staff assessed, managed and reviewed women's pain relief effectively.
- Antenatal screening for blood born infections was offered to women and the service was compliant with national key performance indicators.
- The service provided seven-day services to women to enable them to be seen when they needed to access care and/or advice.
- Staff could explain their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as good because:

- Staff understood and respected the personal, cultural, social and religious needs of women and those important to them.
- Interactions we observed were mainly respectful and understanding, except on one occasion.

Maternity

- Women and their relatives we spoke without exception with told us they were treated with dignity, kindness and respect.
- All women we spoke with within the unit told us that their confidentiality, privacy and dignity was maintained.
- Staff supported women to cope emotionally with their pregnancy, birth, postnatal care and treatment.
- Bereavement services and staff knowledge on supporting bereaved families ensured people received the care physical and emotional care required.
- Staff routinely involved women who used the services and those close to them in planning and making shared decisions about their care and treatment.
- Birthing partners were included and involved in the care of their partner and new-born baby.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as good because:

- Although some services were closed the service continued to provide choice for women. There were a range of clinics and high and low risk services at the unit.
- Interpreting services were available for staff to access when required.
- The service took account of womens' individual needs. Comprehensive handheld records assessed and identified the individual needs of women.
- The service provided a range of specialist clinics and specialist midwives to meet the needs of women using the service.
- The service had recruited a number of specialist midwives to support the women and staff.
- The bereavement room enabled women to be cared for in a home from home environment which supported their partners to stay and baby to be with them for as long as they wanted.
- Partners could stay overnight if the women or baby required extra support.

However:

- Staff told us that leaflets were accessible to print off but were limited in alternative languages or easy read versions.
- There were no displays to inform people how to complain to the service and women we spoke to did not know how to complain.
- Not all women were booked before ten weeks of pregnancy, the service did not meet the trust target.
- Staff were not able to describe any complaint the service had received of if the service had any changes in practice following a complaint.

Maternity

Is the service well-led?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement because:

- Staff could not explain the trusts vision or values.
- Staff morale was mixed, staff were reserved, tired and lacked resilience, they told us this was due to all the reviews that the service had encountered over the last few years.
- Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.
- The arrangements for governance were not always monitored effectively. Attendance was not multidisciplinary, which meant they could not operate effectively.
- Staff were not able to explain what happened to risks and concerns shared at governance meetings and felt that they escalated concerns, but did not see actions or feedback responses from the executive leadership team.
- We were not assured that labour ward forum meetings were held regularly, we requested three sets of minutes and received one.
- Not all risks we encountered during the inspection were added to the maternity risk register. For example, the number of women booked before ten weeks of pregnancy was poor. This had not been identified as a risk by the service.
- The service had recently commenced reporting safety thermometer outcomes April 2018, which were not displayed for staff or the public to see.
- Staff described not being actively involved or engaged in changes within the service, with decisions made at care group level without their involvement.
- Staff were not able to give examples of new initiatives within the unit, although staff were committed to making improvements for women and babies.
- The maternity staff survey results showed a decline from 2015 to 2017, with regard to recommending the trust as a place to work and the extent staff were motivated and engaged in their work.
- We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example or learning.

However:

- Medical staff without exception felt supported by their managers and were complimentary regarding the experiences and training they received.
- Maternity issues were discussed in board meetings although not by the Head of Midwifery, representation was by the Director of Nursing, Midwifery and Quality.

- There were good working relationships between the senior leadership team of the maternity service and the managers of the departments.
- Most of the senior midwifery and medical team and managers were visible and staff told us that they could approach them.
- The trust had appointed a maternity safety champion, in line with national recommendations (Department of Health 'Safer Maternity Care: Next steps towards the national maternity ambition', October 2016). However, the head of midwifery was not appointed, they were the director of nursing, midwifery and quality and the medical director.

Outstanding practice

The postnatal ward had received the exemplar ward diamond status which is the highest possible, staff were very proud of being the first ward within the trust to be awarded this level. To achieve this level the ward met high standards in a number of key areas for example; caring for women and babies, medicine management, leadership, nutrition, hydration, cleanliness, safety and record-keeping.

Areas for improvement

The trust must:

- The trust must ensure that the low risk midwifery pathway is robust and women access the correct pathway of care and give birth in the correct area according to their assessment of risk.
- The trust must ensure staff complete mandatory training in line with the trust target.
- The trust must ensure staff complete adult safeguarding training in line with the trust target.
- The trust must ensure that the lone working policy is adhered to ensure staff safety.
- The trust must ensure that the women's weight is recorded on the prescription charts.
- The trust must ensure handovers are completed regularly and high-risk women in labour are reviewed by medical staff.
- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff.
- The trust must ensure the correct number of anaesthetists are employed as recommended by the Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland 2013 guidelines for obstetric anaesthesia.
- The trust must ensure that the community midwives are carrying the correct equipment to carry out their work in line with best practice.
- The trust must ensure MEOWS charts are fully completed.
- The trust must ensure all staff complete the CTG training defined by the service.
- The trust must ensure that prescription and observation charts are stored confidentially.
- The trust must ensure grading of incidents reflects the level of harm.
- The trust must ensure that the HoM has direct access to the board in line with better births 2016.

The trust should:

- The trust should ensure staff are aware and can explain learning from serious incidents and complaints.

Maternity

- The trust should have identified a plan to work towards compliance with the Department of Heath recommendations 2013 to have ensuite facilities in a labour room.
- The trust should ensure that SBAR forms are fully completed.
- The trust should ensure that midwives prescribing antibiotics comply with the medications policy.
- The trust should ensure all incidents are reviewed and closed in a timely manner.
- The trust should ensure staffing is appropriate on the postnatal ward to enable midwives to care for babies on transitional care.
- The trust should ensure that there is a system in place to know that equipment has been cleaned.
- The trust should ensure that medicines prescribed are in line with the antibiotic formulary.
- The trust should ensure that the safety thermometer results are displayed for staff and the public to see.
- The trust should ensure the time women request an epidural to the time they received one is monitored.
- The trust should ensure the 2018 dashboard is colour coded and an agenda item at maternity governance meetings.
- The trust should share the plans to implement a new process to replace statutory supervision of midwives which ceased in April 2017 with all staff.
- The trust should ensure women receive carbon monoxide screening in line with national guidance.
- The trust should ensure that all leaflets are accessible in different languages and easy to read versions.
- The trust should ensure displays and leaflets are available to inform women how to complain.
- The trust should have a defined maternity strategy.
- The trust should ensure staff are aware of the vision of the service and the trust's vision and values.
- The trust should ensure the executive team are visible and supportive during challenging times within the maternity service.
- The trust should ensure staff morale is reviewed and plan to improve the staff survey results.
- The trust should ensure multidisciplinary attendance at the maternity governance meetings.
- The trust should ensure labour ward forum meetings are held at regular intervals.
- The trust should ensure that all risks within maternity services are added to the risk register.
- The trust should ensure staff are involved with proposed changes and developments.
- The trust should ensure staff engagement and involvement with service changes is improved.

End of life care

Requires improvement 

Key facts and figures

The Shrewsbury and Telford NHS Foundation Trust provides end of life care at Princess Royal Hospital in Telford. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,769 deaths within end of life care from January 2017 to December 2017.

The service was previously inspected in December 2016 and received a rating of requires improvement overall for end of life care with a requires improvement rating for safe, effective, and responsive and good for caring and well-led.

The trust empowers its front line clinical teams on wards to identify and care for end of life patients, these are patients usually in the last few days of life. Ward staff also provide care for palliative care patients living with life limiting conditions. The ward staff can call upon the trust end of life care facilitator or the specialist palliative care team (SPCT) for a wide range of guidance and support including patient symptom management, pain management and supporting fast track discharges out of the hospital.

During our inspection we visited the mortuary, bereavement office, chapel, medical devices library, SWAN rooms, SWAN bereavement centre and various wards across the trust where end of life and palliative care patients may be offered care and support. The SWAN scheme is a national model of care and an acronym for signs, words, actions and needs in the care of the dying. The hospital had many SWAN rooms used by staff to support end of life care patients and a SWAN bereavement centre, using the emblem of a flying SWAN to denote the equipment and environment used to support dying patients.

We spoke with 43 members of staff including a specialist palliative care nurse, ward registered nurses (RN), physiotherapists, occupational therapists, physiotherapists, speech and language therapists, mortuary staff, medical device engineers, chaplain, bereavement team, dieticians and porters. We did not speak to any patients receiving palliative or end of life care support, as only two patients were accessing this support during our inspection. One patient was too ill to speak with us, the other did not want to talk to an inspector and there was no opportunity to meet their family members.

We reviewed 12 patient medical care records, ten of which related to patients who had died whilst on an end of life care plan or having received palliative care support and reviewed two patient medicine charts along with policies, minutes of meetings and procedures.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The mortuary environment was visibly aged and arrangements for viewing deceased children was not ideal due to the low temperatures in the viewing area.
- The service did not provide a seven-day week 24 hour a day end of life or specialist palliative care team. Nurse and medical staffing was not in line with national guidance.
- Staff did not routinely complete the end of life care plan for patient's in their last days of life.

End of life care

- The trust end of life care strategy did not link to national or local objectives in relation to improving end of life care or definitive timescales or commitments to achieve service improvements and none of the staff we spoke with, knew what the vision or strategy was for end of life or palliative care patients.
- There was a lack of psychological support for patients and a psychology service was no longer funded by the service.
- Patients could not access the specialist palliative care team (SPCT) directly. Patients needed to be admitted via the emergency department (ED) for a referral to the SPCT to be triggered, this posed a potential risk to patients receiving appropriate care in a timely way.
- Except for the emergency department, the wards we visited used the SWAN rooms for escalation when patient capacity was high or if a patient needed to be isolated due to an infection. Ward staff said that infection control always superseded the needs of end of life patients.
- The trust did not consistently collect, analyse, and use information to support all its activities. Internal audit processes across the service were inconsistent and audit outcomes were not always used to improve quality and performance of the service. End of life performance measurements were not part of the trusts dashboards, this had not changed since our last inspection.
- The SWAN scheme was not fully embedded, leaders did not ensure that SWAN resources were allocated in an appropriate fashion to support end of life patients.
- The trust identified there was inadequate coverage for end of life and palliative care at the Princes Royal Hospital within end of life care, due to only having one staff member in post and additional limited access to a clinical lead for the service.

However:

- Staff knew how to recognise incidents and report them appropriately. From May 2017 to April 2018, the trust reported no incidents classified as never events within end of life care.
- The service had suitable premises and equipment and controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time and staff kept clear, up to date and appropriate records of patients' care and treatment.
- Staff understood how to protect patients from abuse and knew their roles and responsibilities under the Mental Capacity Act 2005 to support patients that lacked the capacity to make decisions about their care.
- The service took account of patients' individual needs. Nursing staff could access translation services for patients who did not speak English as a first language. The trust had facilities for family members to stay with their relative overnight and the mortuary had facilities for bariatric patients.
- The service treated concerns and complaints seriously, investigated them in line with trust policy.
- Portering staff transported deceased patients to the mortuary in a timely manner.
- The SPCT were proud of the organisation as a place to work and spoke highly of a culture of working together to meet the needs of the patients and their families.
- The hospital had end of life link staff on the wards. The link staff linked in with the end of life care facilitator around end of life care and shared advice and support to other ward staff.

End of life care

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The mortuary environment was visibly aged, arrangements for viewing deceased children was not ideal due to the low temperatures in the viewing area.
- The service did not provide a seven-day week end of life or specialist palliative care team. Nurse and medical staffing was not in line with national guidance.
- Nursing and medical staff did not routinely complete the end of life care plan to support patients in the last days of life.
- Staff stored patient care records in unlocked and often open records trolleys and noted that staff left computer screens open, with patient records on view.
- People could not access the specialist palliative care team (SPCT) directly. Patients needed to be admitted to a ward for a referral to the specialist palliative care team to be triggered.
- One of the qualified end of life nursing team had not completed syringe driver training and the trust could not easily track where syringe drivers were within the service.

However:

- Staff knew how to recognise incidents and report them appropriately. From May 2017 to April 2018, the trust reported no incidents classified as never events within end of life care.
- The service had suitable premises and equipment and controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time and staff kept clear, up to date and appropriate records of patients' care and treatment.
- Staff understood how to protect patients from abuse and knew their roles and responsibilities under the Mental Capacity Act 2005 to support patients that lacked the capacity to make decisions about their care.
- Nursing, medical staff, therapy teams and services across the trust worked together well to deliver care and treatment in a multidisciplinary way for patients receiving palliative care or who were at the end of their life.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Nursing staff could access translation services for patients who did not speak English as a first language. The trust had facilities for family members to staff with their relative overnight and the mortuary had facilities for bariatric patients.
- The service planned for emergencies and staff understood their roles if one should happen.
- At all times during the inspection, we observed staff treating patients with compassion, dignity, and respect. On all the wards we visited staff displayed a culture of compassion and positivity and had a genuine desire to want to provide the best possible care to patients at the end of life.

End of life care

Is the service effective?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust had an end of life strategy, reviewed in May 2017, the strategy did not relate to any national guidance or strategy supporting end of life care.
- The trust did not provide an end of life facilitator or specialist palliative care team (SPCT) as a 24/7 on site service.
- End of life performance measurements were not part of the trusts dashboards, this had not changed since our last inspection.
- Mortuary staff did not have access to the service policies and procedures.

However:

- Nursing, medical staff, therapy teams and services across the trust worked together well to deliver care and treatment in a multidisciplinary way for patients receiving palliative care or who were at the end of their life.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Nursing staff could access translation services for patients who did not speak English as a first language. The trust had facilities for family members to staff with their relative overnight and the mortuary had facilities for bariatric patients.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service caring?

Good  

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

- At all times during the inspection, we observed staff treating patients with compassion, dignity, and respect. On all the wards we visited staff displayed a culture of compassion and positivity and had a genuine desire to want to provide the best possible care to patients at the end of life.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. We found strong caring, respectful and supportive relationships between people who used the service, those close to them and staff.
- Staff provided many examples of when they had gone the extra mile to provide compassionate care including bringing patient's pets into the wards.
- Staff provided emotional support to patients and their relatives to minimise their distress. The trust had a range of support services in place for bereaved relatives including bereavement services and chaplaincy support.

However:

- Staff told us that there was a lack of psychological support for patients and that a previous psychology service was no longer funded by the service.

End of life care

Is the service responsive?

Requires improvement 

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

- Patients could not access the specialist palliative care team (SPCT) directly. Patients needed to be admitted via the emergency department (ED) for a referral to the SPCT to be triggered, this posed a potential risk to patients receiving appropriate care in a timely way.
- Except for the emergency department, the wards we visited used the SWAN rooms for escalation when patient capacity was high or if a patient needed to be isolated due to an infection. Ward staff said that infection control always superseded the needs of end of life patients.
- The end of life care staff and SPCT service was not available as an onsite 24/7 service but operated a telephone advice line out of hours. This posed a potential risk to patients receiving appropriate care in a timely way out of normal operating hours.
- The trust did not provide us with data regarding fast track discharge. The fast track discharge process allows patients whose preferred place of death was not in the hospital setting to achieve a timely discharge. We were concerned the trust was not monitoring fast track discharges or delayed discharges.

However:

- The service took account of patients' individual needs. Nursing staff could access translation services for patients who did not speak English as a first language. The trust had facilities for family members to stay with their relative overnight and the mortuary had facilities for bariatric patients.
- The service treated concerns and complaints seriously, investigated them in line with trust policy.
- Portering staff transported deceased patients to the mortuary in a timely manner.

Is the service well-led?

Inadequate 

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

- The end of life care strategy did not link to national or local objectives in relation to improving end of life care or definitive timescales or commitments to achieve service improvements.
- None of the staff we spoke with, knew what the vision or strategy was for end of life or palliative care patients.
- The trust did not consistently collect, analyse, and use information to support all its activities. Internal audit processes across the service were inconsistent and audit outcomes were not always used to improve quality and performance of the service.
- The SWAN scheme was not fully embedded, leaders did not ensure that SWAN resources were allocated in an appropriate fashion to support end of life patients.
- The trust identified there was inadequate coverage for end of life and palliative care at the Princes Royal Hospital within end of life care, due to only having one staff member in post and additional limited access to a clinical lead for the service.

However:

- The SPCT were proud of the organisation as a place to work and spoke highly of a culture of working together to meet the needs of the patients and their families.
- The hospital had end of life link staff on the wards. The link staff linked in with the end of life care facilitator around end of life care and shared advice and support to other ward staff.

Outstanding practice

The trust has been selected as one of eight trusts to work with National Health Service Improvement and Hospice UK on the ELCHIP (End of Life Care in Hospital Inpatients) project, to improve end of life care in the emergency and acute setting.

Areas for improvement

The trust must:

- The trust must ensure that staff store patient records securely, complete the end of life plan, ensure equipment inventories for syringe drivers are up to date and that mortuary staff have access to the trust intranet, policies and procedures.
- The trust must ensure that end of life performance measurements is part of the trusts quality dashboards and routinely audit and act on data within the end of life care service to drive improvement.
- The trust must ensure that all staff understand and implemented the SWAN scheme and or ensure that resources for the SWAN scheme are prioritised.
- The trust must ensure that the end of life care team have its own dedicated risk register that reflects the risks and management of risks within the service.
- The trust must ensure that end of life patients have appropriate access to mental health input or advice.
- The trust must ensure that equipment is stored safely and that ward areas are free from clutter.

The trust should:

- The provider should ensure that the specialist palliative care team maintain a central list of patients who were receiving specialist palliative care or details of the ward areas where they were being cared for.
- The provider should ensure that it provides it meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is a 9am to 5pm, seven-days per week.
- The provide should ensure that medical staffing meets the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care standard (NCPC) which states there should be a minimum of one consultant per 50 beds.
- The provider should ensure that its end of life strategy links to national and local objectives in relation to improving end of life care and definitive timescales and commitments to achieve service improvements.

Royal Shrewsbury Hospital

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust has approximately 628 inpatient beds and 43 day-case beds and 44 children's beds located across two acute locations: The Princess Royal Hospital which is located in Telford and Royal Shrewsbury Hospital which is located in Shrewsbury. These two hospitals serve an approximate combined population of 420,000. The trust is a major trauma unit for the region. The number of staff employed by the trust as of April 2018 was 5,053. The trusts' services are commissioned by Telford and Wrekin Clinical Commissioning Group (CCG), Shropshire CCG and Powys Training Health Board.

At Royal Shrewsbury Hospital in Shrewsbury, there is an accident and emergency department and a minor injuries unit. It is the designated trauma site and main acute surgical centre, including surgical assessment unit, surgical short stay unit and ambulatory care facilities.

Royal Shrewsbury Hospital provides a range of hospital services, including general medicine including elderly care, elective surgery and a range of outpatient services.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total staffing; trust website)

Summary of services at Royal Shrewsbury Hospital

Inadequate ↓

Our rating of services went down. We rated them as inadequate because:

- Our rating of safe was inadequate overall. Services did not always manage patient safety incidents well. The deteriorating patient was not always recognised within urgent and emergency care services to ensure appropriate and timely care was provided. Not all services had sufficient numbers of permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse. Staff completion data for mandatory training did not meet the trust targets, including Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. There was no data available for adult safeguarding training for medical staff.
- Our rating of effective remained requires improvement overall. Services monitored the effectiveness of care and treatment and used the findings to improve them. However, effective action was not always taken in response to poor audit results to drive improvement.
- Our rating of caring remained as good overall. Staff delivered compassionate care and patients' privacy and dignity was maintained.

Summary of findings

- Our rating of responsive remained as requires improvement overall. The trust did not always plan and provide services in a way that met the needs of local people. Not all services always took into account the individual needs of patients.
- Our rating of well-led went down to inadequate overall. Staff reported a disconnect between them and the senior management team and board. There were systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, timely and effective action was not always taken to mitigate risk. The trust did not always use a systematic approach to continually improve the quality of its services or safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

Urgent and emergency services

Inadequate 

Key facts and figures

This core service report is about urgent and emergency care services at the Royal Shrewsbury Hospital (RSH). A separate report covers activities at Princess Royal Hospital (PRH). There will be similarities between the two reports as the two locations share common governance arrangements, senior management and consultant services.

Royal Shrewsbury Hospital has a trauma unit, minor injuries unit and a clinical decision unit, there is also an urgent care centre (walk-in) co-located within the main emergency department.

Both sites have acute medical units where patients are initially admitted from either the emergency department or through GP referral (referral via the care co-ordination centre). Patients with conditions that can be diagnosed/ treated without the need for admission may be seen and treated in the ambulatory emergency centre (AEC) which is led by GP's and advanced nurse practitioners.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

The Emergency Department (ED) provide services 24 hours a day, seven days a week. There were approximately 61034 attendances between August 2017 to July 2018 of these 9684 attendances were children under the age of 16 years of age.

The ED consists of a waiting area, resuscitation area with four resuscitation bays and a dedicated cubicle for paediatric patients, 12 majors' cubicles, a "pit stop" or rapid assessments and treatment (RAT) room and a minor treatment area with three treatment cubicles. The department is also a recognised trauma unit. Streaming and initial triage took place at the reception with a triage room off the main waiting room, that could be used for a more private triage to take place.

There was one area for 'fit to sit' patients which had chairs where patients, who were well enough, could sit and await discharge or further assessment.

There is also a walk-in centre located adjacent to the waiting area. This facility is managed separately and is staffed by general practitioners (GP's) and support staff.

The ED at Royal Shrewsbury Hospital was last inspected by CQC in December 2016, as part of the comprehensive hospital inspection programme; at that time, urgent care services were rated as 'Requires Improvement'.

Summary of this service

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

- The service did not have enough nursing or medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm.
- We found that medical staff were not up to date with safeguarding level 3 training.
- We found that there was conflicting information with regard to the sepsis bleep system. There were posters declaring that in the event of a patient having sepsis, staff were to call an allocated bleep number, to alert a senior clinician. We found that this system was not in use due to the shortage of medical staff available to hold the bleep. We were not assured that all staff would know the bleep was not always in use. This applied specifically to agency staff and anyone visiting the ED.

Urgent and emergency services

- Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- We saw on several occasions that patients had been waiting for over four hours to be transferred, admitted or discharged from the ED. We noted patients had been waiting longer to be admitted to a ward and in three cases we saw that patients had waited over 12 hours.
- We found that that patients were potentially at risk due to a lack of insight and intervention from some senior leaders. Local leadership was mostly good, however, staff told us there were some inconsistencies, depending on who was managing any given day.
- The trust did not use a systematic approach to continually improve the quality of its services. Governance processes were inconsistent and although concerns were identified, action plans were not robust enough to improve the situation.
- We found that although some concerns regarding ED were on the risk register; the executive team at the trust were unaware of certain decisions that had been taken more locally.

However,

- Staff provided emotional support to patients to minimise their distress. We saw examples of good care being given by doctors, nursing and other healthcare staff. Patients were included in conversations about their care.
- Despite low morale experienced within the department, staff consistently told us they enjoyed their work and were passionate about helping patients. Overall, they felt they could approach their manager, or other staff, if they had a problem or concern.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw good multidisciplinary working practices were evident within the department.

Is the service safe?

Inadequate 

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

- The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm. Nurse staffing was highlighted as a concern at the previous CQC inspection conducted in December 2016. Along with medical staff levels, this was still a concern at this inspection.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm. This had not improved since the last inspection. The previous report stated, “Insufficient numbers of consultants and middle grade doctors were available”.
- Although the service generally had effective systems in place to recognise and respond to deteriorating patients, observations of the patients using the national early warning scoring system was inconsistently applied. In additional documentation around the sepsis pathway was not always followed or correctly completed.
- We found that there was conflicting information with regard to the sepsis bleep system. There were posters declaring that in the event of a patient having sepsis, staff were to call an allocated bleep number, to alert a senior clinician. We found that this system was not in use due to the shortage of medical staff available to hold the bleep. We were not assured that all staff would know the bleep was not always in use. This applied specifically to agency staff and anyone visiting the ED.

Urgent and emergency services

- We found that medical equipment within the department was in good order and fit for purpose. However, there were three cubicles that did not have monitoring equipment or call facilities within them.
- We looked at patient records and found them to be inconsistent. We noted documents were confusing at times, with multiple separate forms in use. We checked historical patient notes to observe how the sepsis pathway and NEWS assessments where completed. We found that all but one was not completed fully and that the NEWS documentation had been photocopied in black and white, making it unclear how the colour coding was used.
- The trust target of 90%, for mandatory training compliance, was not met for nursing or medical staff in some subjects. This included advanced life support and paediatric life support training modules.
- We found that medical staff were not up to date with safeguarding level 3 training. The training completion rate for level 3 safeguarding children, was reported at 35%, which is much lower, than the target of 90%.

However

- We found a positive reporting culture within the emergency department (ED) at Royal Shrewsbury Hospital (RSH). Staff told us that they were encouraged to report incidents by local managers and they said incident reporting culture had improved since the last inspection in 2016.
- There were no never events recorded for the 12-month period prior to inspection, in the ED at RSH.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Waiting areas were visibly clean and tidy. We saw staff cleaning the area at different times of the day and worked to a cleaning schedule and all other all areas within the ED, were visibly clean and tidy.
- The service prescribed, gave, recorded and stored medicines well. Medicines were stored safely behind locked doors or in restricted areas which were only accessible to authorised staff.
- The service planned for emergencies and staff understood their roles if one should happen. The ED had a major incident lead; there were highly visible arrangements for major incidents and public emergencies in place throughout the department. Staff were aware of the procedures if a major incident was declared.

Is the service effective?

Requires improvement 

- Performance against the Royal College of Emergency Medicine (RCEM) national audits was overall worse than the England average and compared to similar trusts.
- The trust performance in relation to sepsis management was significantly lower than expected. The trust did not have effective and robust action plans in place to address these shortfalls. This put patients presenting with these conditions at risk of avoidable harm.
- There was an inconsistent programme of audit activity.
- The system to ensure comfort rounds and patients' needs was not well embedded.
- Staffing at night was sometimes difficult to manage and contingencies were continuously being reviewed to ensure adequate cover. However, senior medical cover was not always provided 24 hours a day, 7 days a week.

However:

- Pain was assessed and managed on an individual basis and was regularly monitored throughout patient care.

Urgent and emergency services

- The service made sure staff were competent for their roles, including the Mental Capacity Act and Deprivation of Liberty Safeguards. Managers appraised staff's work performance and held supervision meetings with them to provide support.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw good multidisciplinary working practices were evident within the department.

Is the service caring?

Good  

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

- Staff cared for patients with compassion even though at times they were busy. However, the arrangements for triage did not always protect people's privacy and dignity.
- Feedback from patients confirmed that staff treated them well and with kindness.
- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from June 2017 to May 2018.
- Staff provided emotional support to patients to minimise their distress. We saw examples of good care being given by doctors, nursing and other healthcare staff. Patients were included in conversations about their care.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- People could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- We saw on several occasions that patients had been waiting for over four hours to be transferred, admitted or discharged from the ED. We noted patients had been waiting longer to be admitted to a ward and in three cases we saw that patients had waited over 12 hours.
- Patient complaints were not always managed appropriately or responded to in line with the time frame stipulated within trust policy.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for all months over the 12-month period from June 2017 to May 2018.

However:

- We found the service to be responsive to individual's needs. The ED was easily accessible for patients using wheelchairs and those with other mobility issues. Doorways and corridors were generally kept free of obstacles and allowed patients with reduced mobility, good access to all areas of the ED.

- Patients identified as vulnerable or with mental health needs, were reviewed in a separate room used for sensitive consultations.
- The children's waiting room was decorated with child friendly images on the walls. A selection of toys and books were available.
- Staff could access specialist or lead nurses to support patients living with dementia or with a learning disability.

Is the service well-led?

Inadequate 

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

- Leaders did not have the necessary experience, knowledge, capacity and capability to lead effectively. There was a high unplanned turnover and vacancy rate. Senior leaders were out of touch with what was happening on the front line, and they had not identified and understood the risks and issues found in the department. There was little attention to succession planning and development of leaders. Staff were unable to access senior leaders. Leaders could not make a demonstrable impact on the quality or sustainability of services. We found that that patients were potentially at risk due to a lack of insight and intervention from some senior leaders.
- There was no current local strategy. Staff were not aware and did not understand how their role contributed to achieving any strategy. There was no credible statement of vision and guiding values.
- There was no real understanding of the importance of culture. There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel valued, supported or appreciated by senior staff. At times morale was low and staff told us they were under pressure due to staffing levels. However, we saw that staff supported each other locally.
- The governance arrangements and their purpose were unclear, and there was a lack of clarity about authority to make decisions and how individuals are held to account. There were unclear processes to review key items such as the strategy, values, objectives, plans or the governance framework. The trust did not use a systematic approach to continually improve the quality of its services. Governance processes were inconsistent and although concerns were identified, action plans were not robust enough to improve the situation.
- There was little understanding or management of risks and issues, and there were failures in performance management and audit systems, which had led to significant concerns being recognised on the trust risk register, some of which had been significant for several years, despite this action to reduce risks had not been implemented.
- There was minimal engagement with people who used the service, staff, the public and external partners. We found that the complete focus for improvement was on the process to decide the future of the ED's across both sites.
- We found that although some concerns regarding ED were on the risk register; the executive team at the trust were unaware of certain decisions that had been taken more locally.
- We saw that the lack of a suitable room for mental health assessment was still on the risk register and the actions did not state that a solution was to refurbish a relative room. This is despite being told and seeing that a new room was in place at RSH.

However:

- Despite low morale experienced within the department, staff consistently told us they enjoyed their work and were passionate about helping patients. Overall, they felt they could approach their manager, or other staff, if they had a problem or concern.
- We saw documented risks, such as medical and nurse staffing, lack of paediatric trained staff and patient flow, which reflected what had been identified throughout inspection.

Areas for improvement

The trust must:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients.
- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts.
- Ensure they provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance.
- Ensure that all assessment forms are appropriate and that early warning scores are recorded on the correct, coloured documentation and not photocopies.
- Review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. This includes the 4-hour waiting target.
- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding.

The trust should:

- Review all policies regarding managing deteriorating patients, especially the use of a bleep system to prioritise patients with sepsis.
- Review departmental risk registers to ensure actions are updated in a timely manner.
- Perform a review of all documentation with regards to patient assessments, to provide consistency across both sites. This review should include all early warning scores that are currently in use and any that are planned to be introduced.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Medical care is provided on both the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital Sites. Services provided on RSH site include: Nephrology (including Renal Dialysis unit), Respiratory, Cardiology, Endocrinology, Care of the Elderly (and Rehabilitation) as well as inpatient Neurology support and speciality outpatient clinics held in the Outpatients department, including Movement Disorders, Neurology, Dermatology and Diabetes.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we visited nine areas in the service in total including: haematology and oncology, respiratory, the acute medical unit, the coronary care unit. The dialysis unit, elderly care, surgical assessment unit, renal and endoscopy. On our inspection we spoke with 47 members of staff including 23 registered nurses, seven doctors, four allied health professionals, two pharmacists, four healthcare assistants and the services leadership team. During our inspection we spoke with eleven patients and one patient's relative.

The care quality commission last inspected the service in December 2016 and rated the service as good overall. Safe was rated as requires improvement and effective, caring, responsive and well led were rated as good at this previous inspection.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff completion data for mandatory training did not meet the trust targets.
- Staff training levels for safeguarding were poor. Only 68% of nurses and 5% of medical staff had completed the module Safeguarding Adults Level 2.
- Infection prevention and control practices were not consistently adhered to within the hospital. Staff did not always wear appropriate personal protective equipment (PPE) and side room doors for infectious patients were consistently left open.
- We were not assured that the service had suitable environments and maintained equipment in a timely way. We saw that the dirty utility facilities on the dialysis unit were in a state of disrepair and there was no piped oxygen on the renal unit. The trust-wide medical devices register showed that amount of equipment had not been seen to be serviced within set timelines.
- We were not assured that risks to patients were always managed positively within the service. Whilst staff within the service used systems to identify deteriorating patients, there was a lack of consistency in sepsis management, a lack of awareness around dietary risks on the renal ward and inappropriate risk assessments for additional patients on wards.
- The service did not always follow best practice when preparing, giving, and storing medicines.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983. They did not know how to support patients in providing them with their rights under Section 2 of the Act.
- Care and treatment did not always reflect current-evidence based guidance standards. Implementation of evidence-based guidance was variable, we reviewed a sample of four clinical guidelines and saw that two were out of date.

Medical care (including older people's care)

- Outcomes for people who use services were below expectations compared with similar services. The service did not meet the national aspirational standards in the National Audit of Inpatient falls and performed significantly worse in some metrics than the national average in the 2017 Lung Cancer Audit.
- There was a lack of knowledge among nursing and medical staff regarding outcomes and action plans from audits.
- We were not assured that the staff had the skills and knowledge to manage issues arising from patients with learning disabilities. No member of staff in the medicine core service had received training on patients with learning disabilities in the last 12 months.
- We were not assured that the trust had effective systems in place to identify all risks. We identified a number of risks on our inspection that did not feature on the trusts risk register including: the low rates of administering antibiotics within one hour of identifying patients with suspected sepsis, the equipment maintenance concerns we identified and the extremely low safeguarding and mandatory training rates.
- The safety performance of the service had deteriorated since our previous inspection. Since our previous inspection mandatory training rates, safeguarding rates and equipment maintenance had deteriorated. We were concerned that there was not a focus on these issues from the service's leaders.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- We were not assured that risks to patients were always managed positively within the service. While staff within the service used systems to identify deteriorating patients, there was a lack of consistency in sepsis management, a lack of awareness around dietary risks on the renal ward and inappropriate risk assessments for additional patients on wards.
- The service provided mandatory training in key skills to staff, compliance was monitored but consistently did not meet the trust target.
- Staff did not know how to protect patients from all kinds of abuse. Not all staff had training on how to recognise and report abuse. Only 68% of nurses and 5% of medical staff had completed the module Safeguarding Adults Level 2.
- The service demonstrated they were proactive in monitoring infection risk but we could not be fully assured that infection prevention and control (IPC) practices were consistently adhered to. Staff did not always wear appropriate personal protective equipment (PPE) and side room doors for infectious patients were consistently left open.
- We were not assured that the service had suitable environments and maintained equipment in a timely way. We saw that the dirty utility facilities on the dialysis unit were in a state of disrepair and there was no piped oxygen on the renal unit. The trust-wide medical devises register showed that amount of equipment had not been seen to be serviced within set timelines.
- The service did not have sufficient numbers of suitably qualified permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse.
- The service had shortages in the acute physician workforce and no overall clinical lead for acute medicine. However, locum arrangements ensured that the service remained safe.
- The service did not always follow best practice when preparing, giving, and storing medicines.

However:

Medical care (including older people's care)

- Staff kept detailed records of patients' care and treatment. Records were clear, up to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Is the service effective?

Requires improvement 

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

- Staff did not understand their roles and responsibilities under the Mental Health Act 1983. They did not know how to support patients in providing them with their rights under Section 2 of the Act.
- Care and treatment did not always reflect current-evidence based guidance standards. Implementation of evidence-based guidance was variable, we reviewed a sample of four clinical guidelines and saw that two were out of date.
- Outcomes for people who use services were below expectations compared with similar services. The service did not meet the national aspirational standards in the National Audit of Inpatient falls and performed significantly worse in some metrics than the national average in the 2017 Lung Cancer Audit.
- There was a lack of knowledge among nursing and medical staff regarding outcomes and action plans from audits.
- We were not assured that the staff had the skills and knowledge to manage issues arising from patients with learning disabilities. No member of staff in the medicine core service had received training on patients with learning disabilities in the last 12 months.
- Staff did not always understand when to assess whether a patient had the capacity to make decisions about their care and did not always follow trust policy and procedures when a patient could not give consent.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.

Medical care (including older people's care)

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

- Patients were boarded on the wards in a way that did not protect their privacy and dignity. Patients were boarded when there were not enough beds in the hospital and therefore temporary bed spaces were created on wards. These patients could not always be screened to allow privacy and were boarded on the same corridor as members of the other sex on the CDU.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs. This included using pilot schemes to help staff understand a patient with dementia's experience, access to 24-hour mental health support and using nurse specialists to provide education on patient's conditions and needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The trust's referral to treatment time was consistently above the England average.
- The service had put in place systems and processes to improve flow and discharges within the hospital.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The service had not embedded the use of the "this is me" for patients with dementia.
- We were not assured that the service adequately catered for patients who had complex needs such as a hearing or visual impairment adequately.
- The service had a high number of "boarded patients" and medical outliers. A medical outlier is a patient with a medical speciality in a bed on a ward which contains no medical beds.
- The service did not monitor bed moves of patients. We were concerned that there was no oversight of bed moves within the trust and therefore work was not being undertaken to improve patient's experience.

Medical care (including older people's care)

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- We were not assured that the trust had effective systems in place to identify all risks. We identified a number of risks on our inspection that did not feature on the trusts risk register including: the low rates of administering antibiotics within one hour of identifying patients with suspected sepsis, the equipment maintenance concerns we identified and the extremely low safeguarding and mandatory training rates.
- The safety performance of the service had deteriorated since our previous inspection. Since our previous inspection mandatory training rates, safeguarding rates and equipment maintenance had deteriorated. We were concerned that there was not a focus on these issues from the service's leaders.
- We were not assured that there were robust arrangements to ensure the confidentiality of identifiable data in line with data security standards.
- Senior members of staff were not required to regularly report on aspects of patients' mental health or emotional wellbeing. We were not assured that emotional wellbeing was prioritised by the service.
- We were not assured that managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was a mixed response from ward managers when we asked if they had any leadership training to assist them with their role. Ward managers that we spoke with told us that they had not been offered any leadership training for their role.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service had effective structures, processes and systems of accountability to feed information about quality, performance and delivery of the strategy from ward level to board level**.**
- The trust was committed to improving services by learning from when things went well and when they went wrong and promoting innovation.

Areas for improvement

The trust must:

- Ensure that the mandatory training rates meet the trust target.
- Ensure that safeguarding training rates meet the trust target.
- Ensure mental capacity assessments are consistently carried out where required.
- Ensure that clinical guidelines are regularly reviewed and contain up-to-date national guidance.
- Ensure that all equipment is reviewed within trust and manufacturer guidelines.
- Ensure that dietary risks to renal patients are identified and actioned appropriately.

Medical care (including older people's care)

- Improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis.
- Ensure best practice is followed when preparing, administering and storing medicines.
- Ensure that it has appropriate processes and governance in place to ensure that patients detained under the Mental Health Act 1983 receive the right to appeal the detention.

The trust should:

- Improve training rates for learning disability training among staff within the service.
- Improve its timeliness when investigating complaints.

Surgery

Requires improvement 

Key facts and figures

Surgery services provided by Shrewsbury and Telford NHS trust are located on two hospital sites which provide both elective and emergency surgery to the population of Shrewsbury, Telford, Wrekin and the wider areas.

Royal Shrewsbury Hospital, Shrewsbury and The Princess Royal Hospital, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the Scheduled care group across both hospitals with the same clinical directors. For this reason, there may be some duplication contained within the two evidence appendices.

This report relates to surgery services provided at Royal Shrewsbury Hospital, Shrewsbury, which provides both elective and emergency surgery.

We inspected the service from 21 to 23 August 2018 and as part of the inspection we visited the following areas:

- Pre-assessment clinic
- Surgical assessment suite
- Surgical assessment unit and ambulatory care clinic
- Day case unit
- Day surgery theatres and main theatres
- Recovery area
- Ward 25 and ward 26

During the inspection visit, the inspection team:

- Spoke with 14 patients and four relatives.
- Reviewed 11 patient records;
- Observed staff caring for patients within scheduled care wards and theatres.
- Reviewed trust policies and procedures.
- Reviewed performance information and data from, and about the trust.
- Spoke with 22 members of staff including nurses, doctors and members of the multidisciplinary team.
- Met with service manager, matron and director of nursing, midwifery and quality.

The trust had 31,041 surgical admissions from February 2017 to January 2018. Emergency admissions accounted for 12,104 (39%), 15,362 (50%) were day case, and the remaining 3,575 (12%) were elective.

Royal Shrewsbury Hospital provides the county wide surgical admissions suite taking all surgical emergency admissions through General Practitioner (GP)/Emergency Department (ED) referral and trauma services for the local population. The suite is a dedicated area with assessment rooms, recliner chairs and trolleys. There are 11 theatres at RSH (two were currently closed).

The service was last inspected in December 2016.

Surgery

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

At the last inspection it was rated as requires improvement overall including safe, responsive and well led. It was rated as good for effective and caring. We looked at the changes surgical services had made to improve the service during this inspection.

Our overall rating stayed the same. We rated it as requires improvement because:

- The management of sepsis was still being embedded; audits showed low compliance with the treatment process.
- Mandatory training was provided however the service did not ensure that all levels of staff attended within the timeframe, set at the beginning of the year.
- Although staff understood how to protect patients from abuse, low safeguarding training completion rates did not assure us that staff were updated and competent.
- The service had did not have sufficient permanent staff with the right qualifications, training and experience to keep people safe.
- Patient records were not securely stored to maintain patient confidentiality.
- Boarding of patients was instigated by the trust to keep patients safe when there was no space in the emergency department. We identified inappropriate, undignified boarding of patients during the inspection.
- A seven-day service was not fully integrated for scheduled care.

However:

- Patients were appropriately assessed before surgery and safety measures were in place to monitor their well-being during and after surgery.
- All clinical staff we spoke with demonstrated a good understanding and knowledge of the principles of patient consent.
- Nursing staff used national early warning scores (NEWS) to assess and monitor a patient's condition electronically and in paper format.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Patients told us they had been given enough food and drink to meet their needs and improve their health.
- We found that there was an established multidisciplinary team (MDT); teams worked well together to improve the effectiveness and timeliness of care.
- Patient feedback was positive about care and compassion; patients told us they felt safe.
- The environment was clean and tidy but in need of some repair.

Is the service safe?

Requires improvement 

Surgery

Our rating of safe stayed the same. We rated it as requires improvement because:

- The sepsis 6 bundle had been introduced at the trust but not all staff were familiar with the process and we did not have full assurance that appropriate action would be taken.
- Although most staff complied with the infection control policy some staff were seen to disregard it. For example, a surgeon wearing a long-sleeved shirt on the ward.
- The service provided mandatory training however it did not ensure that all levels of staff attended it within the timeframe set at the beginning of the year.
- The 90% trust target was not met in any of the nine mandatory training modules for which qualified nursing staff were eligible.
- The 90% trust target was not met in any of the eight mandatory training modules for which medical staff were eligible.
- Although staff understood how to protect patients from abuse, training completion rates were below the trust target and we were not assured that staff were appropriately updated and competent.
- The service did not have sufficient permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse.
- Patient records were not securely stored to maintain patient confidentiality.
- Building repairs were evident and staff told us there were delays in building repairs being completed.
- Continuous improvement and learning from incidents was not evident across all areas.
- Tablets to take home were being delayed which caused discharge of patients to be prolonged on the day unit.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Patients' individual needs were recorded and risk assessed to maintain their safety. Patients with complex conditions were supported by the staff and fully updated about their progress.
- The National Early Warning System (NEWS) was used electronically and in paper form and staff were competent in identifying and responding appropriately to a deteriorating patient for medical emergencies.
- Patients were appropriately assessed before surgery and safety measures were in place to monitor their well-being during and after surgery.
- Staff were knowledgeable about escalation of deteriorating patients.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Medical staff reported good consultant support.
- Staff collected safety information and shared it through the quality board with staff, patients and visitors.
- The premises and equipment were generally well looked after. Equipment was found to be clean and suitably maintained.

Surgery

Is the service effective?

Requires improvement  

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

- The fractured neck of femur pathway had not been developed. In the 2017 National Hip Fracture Audit the proportion of patients having surgery on the day of or day after admission failed to meet the national standard. The proportion of patients not developing pressure ulcers also failed to meet the national standard of 100%. The length of stay was 18 days, which fell within the middle 50% of trusts.
- Seven-day service was not fully integrated in to the service. Physiotherapists, pharmacy services and occupational therapists did not work at weekends.
- The Mental Capacity Act advanced level two training had been removed due to low attendance. We gained assurances that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, although the low training level compliance did not support this.
- In the 2016 National Emergency Laparotomy Audit (NELA), Royal Shrewsbury Hospital achieved an amber (50% - 80%) rating for the proportion of cases with pre-operative documentation of risk of death, for the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre and for the proportion of highest-risk cases admitted to critical care post-operatively. Action plans were in place.
- All clinical staff we spoke with demonstrated a good understanding and knowledge of the principles of patient consent.

However:

- The service provided care and treatment based on national guidance and there was some evidence of its effectiveness.
- We found that there was effective multidisciplinary team (MDT) working established in the hospital; teams worked well together to improve the effectiveness and timeliness of care.
- The service managed patients' pain effectively and provided or offered pain relief regularly.
- Staff received a comprehensive induction when they commenced work at the trust. Agency staff received a trust induction and completed ward based competencies.
- Patients told us they had been given enough food and drink to meet their needs and improve their health.
- Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.

Is the service caring?

Good  

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

- Patient's told us they felt safe. We heard feedback that was positive about the care and compassion shown to patients and their relatives.

Surgery

- We heard that staff respected their privacy and dignity and we observed staff maintaining patient's dignity before going into theatre, during and post-surgery; curtains were pulled around the bed space during private discussions and personal care.
- Staff offered emotional support to relieve patient anxiety.
- Patients' spiritual needs were taken into account irrespective of any religious affiliation or belief. The lead chaplaincy service supported spiritual care across all services and ensured that the delivery of spiritual, pastoral and religious care was adequate and appropriate.
- Staff recognised when patients and their families needed additional support to enable them to be involved in their care and treatment.

Is the service responsive?

Requires improvement 

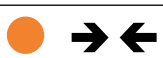
Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust planned the service to meet the demand; however, the demands for the service caused pressure in the system.
- Boarding of patients was instigated by the trust to keep patients safe when there was no space in the emergency department. We identified boarded patients during the inspection. Boarding of patients we observed was unsafe and undignified. The trust suspended the practice following the feedback at the end of the day.
- The referral to treatment rates for surgery showed that four of the five specialties were below the England average. It was recognised that the number of patients waiting over 52 weeks for a procedure had continuously decreased since our last inspection. Staff within specialities understood the importance of ensuring all patients waiting had their risk of harm reviewed.
- Staff told us they treated concerns and complaints seriously. Although we heard that complaint handling was not always managed appropriately, executives did not always sign off responses.

However:

- Patients with sensory loss were identified during referral and pre-admission stages. Appropriate support was arranged before admission.
- The trust created patient passports for those who needed them. This document, completed by staff, helped individuals to communicate their specific needs as a patient.
- Staff were knowledgeable about how to support patients with complex needs such as dementia or a learning disability.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The trust systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not always effective due to the capacity demands.

Surgery

- Staff told us that the lack of visibility of senior executives resulted in low staff morale during busy periods and low staffing levels.
- Administration and management were described as overbearing. Staff told us there was 'lip service' paid to safety with a financial influence.
- Lone workers told us that they felt vulnerable. Security alarms were promised but not supplied.
- The trust used a systematic approach to improve the quality of its services and safeguarding standards of care. However, staff told us that delays in actioning requests resulted in delays in improvements. We were not assured that there were procedures in place for lessons learnt to be fed back to staff in a timely manner.

However:

- Managers across the surgical service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Staff listened to patient feedback and displayed actions on 'you said ~ we did' boards
- The trust was committed to improving services by reflecting on when things go well and when they go wrong, although the we identified poor compliance of the trust training targets.
- Transforming Care Institute was developing leaders to apply the principles of lean across the organisation. Learning to apply key tools to improve effectiveness.

Areas for improvement

The trust must:

- Ensure that sufficient permanent staff are employed to keep people safe from avoidable harm and abuse and that they attend safeguarding training in line with the trust target.
- Ensure all staff complete mandatory training, MCA training and become familiar with lessons learnt.
- Ensure records are stored safely and confidentiality is maintained.
- Ensure staff are confident with the procedure for sepsis management.

The trust should:

- To continue progress to integrate a seven day service.
- Address issues regarding staff not adhering to infection control policy
- The management of complaint handling should be reviewed.
- Attend to building repairs in a timely way.

Critical care

Requires improvement 

Key facts and figures

Royal Shrewsbury Hospital adult critical care services provide have 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 623 patients between 1 April 2017 and 31 March 2018.

We inspected both the ICU and HDU at Royal Shrewsbury Hospital. The trust has another critical care unit at Princess Royal Hospital. Information about this service is included within the Princess Royal Hospital location report.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During this inspection we talked with five patients, two relatives and 23 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.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The critical care unit did not meet current standards and there were not timely plans in place to address this.
- Although there had been improvements to nursing and medical staffing which now meet core intensive care standards, staffing of allied health professionals continued not to meet the required standards.
- Arrangements to ensure the availability of the hospital at night team were not robust and meant that sufficient staff were not always available to assess and treat deteriorating ward patients.
- The number and availability of allied healthcare professionals to provide care and treatment for critical care patients did not meet the required standards.
- Most staff were competent to undertake their roles. However, appropriate arrangements were needed to ensure the continuing development of critical care staff to meet intensive care standards.
- Multidisciplinary team (MDT) working was not always joined up across critical care. Health professionals (doctors, nurses and allied health professionals) had separate handovers which meant there was not discussion amongst all critical care health professionals for a full and rounded review of patients.
- Staff compliance with Mental Capacity Act (MCA) and Deprivation of Liberty training was extremely low.
- Consent to care and treatment was not always sought in line with legislation and guidance. Staff did not have sufficient knowledge or understanding of mental capacity act and deprivation of liberty safeguards. Because of this regulation had been breached and we were aware that one patient had been restrained, sedated and ventilated without the required safeguards in place.
- Although patient's admission to critical care was mostly timely patient's discharge from critical care was frequently delayed which also resulted in mix sex accommodation breaches.

Critical care

- The trust planned to provide a modern critical care unit however the identified timescale was not realistic and meant that the needs of local people were not fully or appropriately met.
- Managers within critical care had the right skills and abilities to provide the service. However, there was lack of overarching managerial arrangements to ensure a coordinated critical care service for doctors across both the trust's hospitals to provide safe, high-quality and sustainable care.
- Managers within the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, there was a need to ensure this was consistently displayed by other managers outside critical care.
- There was an inconsistent approach to service delivery and improvement. Managers, who worked within critical care identified where risks were and where improvements were needed to meet required standards. However, the response from more senior managers was slow and failed to recognize the needs of a critical care service and its patients.
- Although the service provided mandatory training in key skills for all staff most medical staff had not completed it.

However:

- Patients were treated with kindness and compassion and they and their loved ones were involved in decisions about their care and treatment.
- There were sufficient nurses and doctors available with the right skills, training and experience to provide the right care and treatment within critical care.
- Most nursing and ancillary staff had received required mandatory training including safeguarding training. Compliance with mandatory training had improved as staff were able to access to mandatory training and had resulted in critical care unit achieving the diamond exemplar award (the trusts highest quality award).
- Arrangements for the prescribing, administration and storage of medicines were appropriate.
- There were appropriate systems in place to report incidents and staff were mostly confident to do so.
- The service treated concerns and complaints seriously, investigated them and when needed lessons were identified and learnt.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The size and layout of the intensive care unit did not meet current standards. Although there was mostly suitable equipment available there was a need to improve storage arrangements with appropriate arrangements to update and look after it.
- Arrangements to ensure the availability of the hospital at night team were not robust and meant that sufficient staff were not always available to assess and treat deteriorating ward patients.
- The number and availability of allied healthcare professionals to provide care and treatment for critical care patients did not meet the required standards.
- Cover from the critical care outreach team was limited as it only operated from 7.45am to 8pm.

Critical care

- Although the service provided mandatory training in key skills for all staff most medical staff had not completed it.

However:

- There were sufficient nurses with the right skills, training and experience to provide the right care and treatment within critical care.
- Critical care at Royal Shrewsbury Hospital had appropriate medical staff available, with the right skills, qualifications and experience.
- The service controlled infection risk well. Staff kept themselves and the premises clean. Equipment was also mostly visibly clean.
- There were appropriate systems in place to assess and respond to patient risk within critical care.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service used safety monitoring results to improve the service provided.
- Most nursing and ancillary staff had received required mandatory training including safeguarding training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse.

Is the service effective?

Requires improvement 

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

- Most staff were competent to undertake their roles. However, appropriate arrangements were needed to ensure the continuing development of critical care staff to meet intensive care standards.
- Multidisciplinary team (MDT) working was inconsistent and not always joined up across critical care. Nursing and medical staff undertook handovers separately, with little input from each other. Allied health professionals (for example physiotherapy and dieticians) did not attend medical handover to ensure a full and rounded review of patients.
- Staff had limited knowledge, training and understanding of the mental capacity act, best interest's decisions and the deprivation of liberty safeguards. Because of this consent to care and treatment was not always sought in line with legislation and guidance.
- Whilst care provided on the critical care unit mostly met evidence based practice there was a need to ensure patients received appropriate rehabilitation physiotherapy.

However:

- Patient's nutrition and hydration needs were met by competent staff on the ward and a dedicated dietician.

Critical care

- There were appropriate systems in place to identify pain and keep patients pain free.
- The service monitored the effectiveness of care and treatment and used the findings to improve.
- Critical care services and most staff that provided critical care and treatment were available seven days a week.

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion. Feedback from patients and their loved ones confirmed that staff treated them with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

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

- The trust planned to provide a modern critical care unit however the identified timescale was not realistic and meant that the needs of local people were not fully or appropriately met.
- Whilst the service mostly took account of patients' individual needs, there remained issues around mixed sex accommodation.
- Although patient's admission to critical care was mostly timely patient's discharge from critical care was not timely and was frequently delayed.

However:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Is the service well-led?

Requires improvement ➔➔

Our rating of well-led stayed the same. We rated it as requires improvement because:

- There was a lack of short term strategy to provide high quality critical care until the availability of a new critical care unit.
- The service did not have a clinical director and this impacted on the overall clinical leadership.
- Managers within critical care had the right skills and abilities to provide the service. However, the medical clinical lead had no identified management time to manage and develop the service.

Critical care

- There was lack of overarching managerial arrangements from outside critical care to ensure a coordinated critical care service for doctors across both the trust's hospitals to provide a safe, high-quality and sustainable care.
- Managers within the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, there was a need to ensure this was consistently displayed by other managers outside critical care.
- The performance of the unit was monitored by managers. However, response to risks such as not meeting required intensive care standards were not always dealt with appropriately or in a timely way by the trust.
- There was an inconsistent approach to service delivery and improvement. Managers, who worked within critical care identified where required improvements were needed but the response from more senior managers was slow and failed to recognize the needs of a critical care service and its patients.
- Although the service engaged and involved most staff to ensure their voices were heard and acted on this was not the situation for staff who worked within the hospital at night team.
- There were information systems available to inform managers and staff about the service. However, there was a need to ensure that this information was used to fully assess and when required act to improve patient experience and the performance of the unit.

However

- There was a clear statement of values, driven by quality and safety.

Outstanding practice

The service and its staff had demonstrated improvement and learning as part of their journey to achieving the trust's diamond excellar award.

Areas for improvement

The trust must:

- Ensure that requirements of national standards are met.
- Ensure there are sufficient staff (physiotherapists, nurses, dieticians) with the right skills to meet patients' needs and meet required intensive care standards.
- Ensure staff have training and understanding of deprivation of liberty safeguards to ensure that the requirements of the regulations are appropriately met.
- Ensure arrangements for the availability of the hospital at night team are robust to ensure there are sufficient and appropriate staff available to assess and treat deteriorating ward patients.
- Ensure consent to care and treatment including deprivation of liberty is be sought in line with legislation and guidance.

The trust should:

- Ensure there is consistent input from allied health care professionals into ward rounds which is in line with best practice and guidance.
- Ensure monthly mortality and morbidity meetings take place, are recorded and any learning shared with the appropriate parties.

Critical care

- Ensure the cover provided by the critical care outreach team complies with required standards.
- Ensure that appropriate audits are carried out and used to improve the performance of the unit and outcomes for patients.
- Multidisciplinary team (MDT) working should be joined up across critical care to ensure there is coordinated MDT patient review and management.
- Ensure all relevant policies are up to date.
- Ensure that compliance with Mental Capacity Act and Deprivation of Liberty training complies with trust targets.
- Staff should have training and appropriate knowledge of the deprivation of liberty safeguards.
- Ensure the use of diaries is offered to patients to help them, or their loved ones, document the events during their admission.
- Review the provision of physiotherapy resource to improve compliance with NICE Guidance 83 (Rehabilitation after critical illness in adults).
- Ensure the leadership of the critical care unit is effective.
- Ensure there are effective systems to assess, monitor and review the performance of the unit so the safety and quality of care provided can be improved.

Maternity

Requires improvement

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust provides maternity services at the Royal Shrewsbury Hospital. The maternity services available to women include home birth, a midwifery led unit (MLU), one birthing room, a range of antenatal clinics including ultrasound scanning and a day assessment unit (DAU),

Specialist midwives were available to support the women and midwives. Additional antenatal, maternity led birthing unit, consultant led unit and antenatal and postnatal wards were provided at the Princess Royal Hospital Telford.

The trust also employs community midwives, who provide care for women and their babies both during the antenatal and postnatal period and provide a home birth service. The community midwives are aligned to the local GP practices.

Our inspection was unannounced in accordance with our new inspection methodology.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

We previously inspected maternity jointly with gynaecology therefore we cannot compare our new ratings directly with previous ratings.

During this inspection we:

- Spoke with 22 staff members; including service leads, matrons, midwives, midwife sonographers, non-registered and administrative staff.
- Spoke with 20 women who were using the service.
- Checked 15 pieces of equipment.
- Reviewed 11 antenatal records.

The MLU at Shrewsbury was operating from a temporary unit as the previous MLU had been closed due to flood damage. The following services shared the unit: MLU, community nurses office, one birthing room, midwife sonographers, antenatal clinics, Early Pregnancy Advisory Service (EPAS) and the Day Assessment Unit (DAU).

Initially (February 2018) the unit was meant to be temporary for eight weeks but the new unit was not ready in that time. Staff had now been informed by the trust that the new MLU would be ready by early October 2018.

The trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to review current practice within their maternity services in 2017. Following a raised concern by a number of families the home secretary requested a review of a number of previous cases this was completed last year and the trust were awaiting the report

Summary of this service

- At our last inspection the service was rated GOOD overall in all five domains. In this inspection the service was rated as Inadequate in safe, Requires Improvement in effective, responsive and Well Led and Good in caring. This means that maternity services are rated Requires Improvement overall.
- Our rating of this service went down. We rated it as requires improvement because:

Maternity

- The environment of the Shrewsbury MLU was unfit for purpose in that the temporary environment was cramped with five services working alongside each other within a small area. This posed a fire risk and infection control issues.
- There was no clear process for accessing medical reviews of women who presented on the Day Assessment Unit (DAU) as being high risk or risk had increased. Medical reviews could not always be accessed in a timely way. There was no defined pathway for supporting women with reduced fetal movements.
- The service did not assess, monitor or manage women with high risk pregnancies in the correct environment with the support of medical staff. This meant that if risks were identified there was a delay in transferring women to the obstetric led unit.
- There was a shortage of midwives mainly due to sickness and maternity leave.
- A number of NICE guidelines and operational policies were out of date.
- The service treated concerns and complaints seriously, but investigations and outcomes were not always completed in a timely manner nor in line with the trust's own complaints policy
- The Head of Midwifery (HOM) did not have direct access to the board. This was not in line with recommendations from 'Spotlight on Maternity' 2016.
- Local leaders felt disconnected from senior leaders.
- There was a lack of clear strategy for staff at all levels of the service.
- The scrutiny of the midwifery service had been extensive since the last inspection and was still on going. The numerous reviews and action plans were distracting managers from service progression.
- The trust did not have robust systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected.
- The trusts vision and values was not always shared with staff's understanding of these.

However:

- Staff were kind, caring and considerate and women were happy with the care they were receiving.
- Staff were competent and were supported to develop their skills and knowledge
- There was a new governance team and staff could see improvements in governance
- Incidents were reported and investigated and staff said feedback to them had improved
- The introduction of 'safety huddles' presented staff with a daily opportunity to discuss work load, acuity, risks and incidents.
- Staff thought local management was good and they felt supported by the local managers.

Is the service safe?

Inadequate 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

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

Maternity

- The trust target of 90% compliance was not met for mandatory training.
- Staff said it could be difficult for them to complete mandatory training as they were sometimes unable to participate in on line training because of the poor connectivity of the IT system. Also midwives had very little time to complete on line training due to having to cover extra shifts because of staff shortages.
- The temporary environment of the Shrewsbury MLU was very cramped and cluttered and there were issues with the control of infection and fire risk. During our inspection, we requested visits from the fire safety officer and the infection control nurses who were reviewing the risks and introducing action plans in order to make the environment safer.
- Some medicines and Control of Substances Hazardous to Health (COSHH) products were not stored securely and appropriately. These included medicines contained in a Post-Partum Haemorrhage (PPH) box, intravenous fluids and oxygen cylinders. The manager of the MLU provided a locked room for these products to be stored securely during the inspection.
- Access to medical staff was not always available in a timely way. There were delays in accessing medical assessments for women when pregnancy risks increased. Doctors at The Princess Royal Hospital, Telford were not always available to speak with midwives in order to plan care and carry out a medical review.
- The service did not assess, monitor or manage women with high risk pregnancies in the correct environment with the support of medical staff. This meant that if risks were identified there was a delay in transferring women to the obstetric led unit.
- Midwives sometimes felt pressurised to care for women on the Shrewsbury MLU when they felt the women would be best managed on the consultant led unit due to their high risk.
- There was no clear/defined pathway for midwives to follow when women presented with reduced fetal movements and this could lead to confusion and delay with receiving medical reviews and planning care.
- Community midwives were provided with a safety device which could be triggered alerting emergency service assistance, this was in line with the trust's 'Lone Working & Peripatetic Policy'. Midwives told us they did not use the devices which meant they were putting themselves at risk whilst working alone.
- There was a shortage of midwives mainly due to sickness and maternity leave. The trust reported sickness levels of midwifery staff at Royal Shrewsbury Hospital as 6.8% against a trust target of 4%. Most community and senior (band 7) midwives worked part time (40% across the trust) and at Royal Shrewsbury Hospital there was a whole time equivalent shortage of 2.8 midwives.

However:

- There was a robust system in place for safeguarding women and babies and training staff in safeguarding. Midwives had met the targets for safeguarding children training levels two and three and had almost met the target for safeguarding adults level two.
- There was a good support network in place for women who were at risk of harm known as the Supporting Women with Additional Needs (SWAN) team. The team worked with other agencies to ensure women and babies were kept safe.
- Women received detailed risk assessments at their initial booking visit with the community midwife and women were monitored at each antenatal appointment to check if their risk assessment had changed. A plan of care including how the health of the woman and the pregnancy would be managed was established at this early stage based on risk.
- Safety Huddles had been introduced since our last inspection. These presented an opportunity for staff discussion around acuity, risk, staff availability, training and incidents/feedback.

- Midwives followed best practice when prescribing, administering, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Incidents were reported, investigated and feedback was provided. Midwives thought this process had improved since the last inspection.

Is the service effective?

Requires improvement

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

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

- Out of 15 NICE guidelines reviewed, three were out of date
- Out of five operational policies reviewed, two were out of date.
- We escalated the out of date guidelines and policies at the time of the inspection to the Deputy Head of Midwifery (HOM). The guidelines on 'Maternal Death' were updated during the inspection period.
- Women's choice of pain relief at Shrewsbury MLU was limited due to the current environment with the lack of availability of the birthing pool. There was little evidence of the use of alternative therapies such as hypnobirthing.
- At 6.01 the perinatal mortality rate for the trust was 10% higher than the national average of 5.19.
- Staff did not always have access to up-to-date, accurate and comprehensive information on women's' care and treatment**.** This meant that there was not always effective team working due to a breakdown in communication. For example, social services emailed a midwife with a specific birth plan for a woman. The midwife was on leave and the woman gave birth over the weekend on the labour ward at The Princess Royal Hospital. Vital information about the woman and the baby's care was not shared with the delivery team there.
- Telford SWAN and Shrewsbury SWAN teams did not usually meet together and there was sometimes a lack of communication between Shrewsbury and Telford Local Authorities. This meant information was not routinely shared and vital information about women could be missed.

However:

- Care and treatment was delivered in line with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- Community midwifes offered home births to low risk women. The service had a home birth rate higher than the national average of 2.5%.
- There was a competency programme in place for midwives and Woman Support Assistants (WSAs) which helped with their progression and development of skills.
- The trust had started the process to train three midwives to be professional midwifery advocates (an experienced practising midwife who has received specific training to support midwives) to develop a new process to support and supervise midwives based on the NHS England March 2017 national guidance advocating for education and quality improvement (A-EQUIP).

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act (MCA)2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff received training in MCA.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

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

- Women were treated with kindness, care and compassion.
- Staff cared for women with compassion which sometimes went over and above their job role. For example, when a woman was unable to attend any of the antenatal classes due to lack of transport, the midwife offered to come and do some antenatal classes for her at home.
- A poster displayed in the Shrewsbury MLU outlined that the trust had a 'Culture of Compassionate Care' and values based on the six Cs: Care, Compassion, Compliance, Communication, Caring and Commitment.
- Staff supported women to cope emotionally with their pregnancy, birth, postnatal care and treatment.
- For women who had had a difficult and/or traumatic experience during pregnancy, labour and birth, midwives ran a debrief service known as 'Talkabout'. This provided an opportunity for women to talk about their experiences and discuss with midwives.
- Following a pregnancy loss, women and their families were supported by midwives. The trust employed a bereavement midwife who offered additional support to the women and staff. The service supported women and families to make memories of their loss.
- Chaperones were offered to women and provided if required during treatments or examinations.
- The SWAN team provided emotional support for women with additional needs.
- We observed staff involving women and their partners in planning their care. For example during a first antenatal booking clinic, the midwife gave explanations to the woman and her partner and included them both in discussions. The trust had completed a Maternity survey 2018 about how they involved and listened to women.
- Staff involved patients and those close to them in decisions about their care and treatment. New mothers using the services felt that they were treated with respect and dignity, listened to and given the help they needed. Women who raised concerns during their pregnancy or delivery had those concerns taken seriously and were spoken to in a way they could understand.
- The trust scored eight out of ten or higher in 42 out of the 51 categories relating to the care of mothers and babies and the trust performed statistically better than most other trusts in 12 categories.

However:

- The current environment of the Shrewsbury MLU did not lend itself to promoting privacy and dignity for women using the service. The lack of rooms and close proximity of other services meant women's privacy and dignity were compromised.

Maternity

Is the service responsive?

Requires improvement

- We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.
- Our rating of responsive went down. We rated it as requires improvement because:
- There was limited availability of accessible information in different languages, picture formats, and cue cards. However, staff used a language line service for women whose first language was not English.
- Staff worked hard during antenatal clinics to ensure the flow of women through the Shrewsbury MLU department. However, this was difficult given the cramped environment in which they were working. For example, the consultant-led antenatal clinic was co-located with the Day Assessment Unit (DAU) and the Early Pregnancy Advisory Service (EPAS) and the birthing room. This was cramped giving little room for women, partners, children and staff in corridors and rooms.
- Due to the environmental conditions at Shrewsbury MLU it was difficult to differentiate between each area/clinic.
- Women looked confused when they arrived at Shrewsbury MLU and unsure where they were going. There was some signage on walls including signs to apologise for the inconvenience of the environment.
- Women were unhappy about the waiting times in DAU at Shrewsbury MLU. A woman had to wait five hours whilst midwives tried to communicate with medical staff at The Princess Royal Hospital in order to receive a plan of care.
- The current MLU at Shrewsbury had one delivery room and no birthing pool so choice for women was limited.
- The service treated concerns and complaints seriously, but investigations and outcomes were not always completed in a timely manner nor were they in line with the trust's own complaints policy.

However:

- Women were supported to have a home birth if they opted for this.
- As well as clinics on the Shrewsbury MLU, clinics were run from GP surgeries so women did not have to travel far. Most community midwives were attached to a specific GP practice so women tended to see the same midwife, which helped with continuity of care. Where this was not possible, community midwives were divided into small groups of three or four midwives (Better Births) so women saw midwives from the same team.
- The SWAN team provided care and support for women with additional needs.
- Midwives were aware of women's' individual needs and social circumstances and we observed positive and supportive discussions between the midwives women.
- Joint clinics were arranged at Shrewsbury MLU to meet the needs of women. These included endocrinologists, obstetricians, specialist midwives, nurses and a women's' support assistant (WSA) with an interest in diabetes.

Is the service well-led?

Requires improvement

Maternity

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

Our rating of well-led went down. We rated it as requires improvement because:

- The Head of Midwifery (HOM) did not have direct access to the board. Risks issues and concerns had to be escalated through the care group director (CGD) and director of nursing, midwifery and quality (DON) who discussed them on their behalf at board level. This was not in line with recommendations from 'Spotlight on Maternity' 2016.
- Staff said senior managers and board members did not visit the Shrewsbury MLU very often. Some staff did not know who they were.
- There was a clear disconnection between the passion of the local leadership and senior leadership and the views and suggestions of local managers were not always considered.
- There was a lack of clear strategy for staff at all levels of the service.
- Staff thought the trust did not work collaboratively with them to ensure they had a shared vision and strategy.
- Staff on the Shrewsbury MLU and in community had not always felt that they were supported and valued by senior managers. This had failed to create a sense of common purpose based on shared values.
- The scrutiny of the midwifery service had been extensive since the last inspection and was still on going. The numerous reviews and action plans were distracting managers from service progression and managers wanted to 'get on with managing'.
- This had had a negative impact on staff morale and culture as staff felt tired, demoralised and under pressure. Staff sickness had increased, causing more pressure on staffing numbers. Not all staff had felt included in decisions regarding the closures of the MLUs.
- The trust did not have good systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected.
- Following a maternal death in December 2017 we found the trusts' own policy on 'maternal death' was out of date and not all staff had felt included in the discussions around this and had felt 'left out'.
- Staff felt that the trust had not acted quickly enough to provide a suitable temporary environment for the Shrewsbury MLU following flooding. Also the current environment was not fit for purpose and senior staff had been 'crisis managing' since February 2018.
- There was a lack of information displayed in the Shrewsbury MLU area regarding data, activities and outcomes.
- There were mixed feelings about how well the trust engaged with staff about planning and managing maternity services. For example, staff felt let down with how long the new Shrewsbury MLU was taking to open and how long they were having to 'make do' with the current environment.
- There had been little time for innovation on the Shrewsbury MLU/Community as the challenges with the environment had taken precedence. Staff and managers spoke of the challenges just to manage day to day activities. Managers said they were 'crisis managing' due to reduced staffing levels.

However:

- Local leadership was visible, passionate and supportive. Local managers displayed good leadership skills and worked alongside staff.
- Monthly clinical governance meetings were held at speciality, divisional and trust wide level although staff were unsure how this worked and how information was fed upwards and back down again.

Maternity

- Since the last inspection a new governance structure had been implemented, this included a women and children's' governance director, a patient quality and governance midwife (women and children), an audit officer and quality officer.
- There was a 'Quality Improvement Lead Midwife' and 'Midwife Risk Lead' who were professionally accountable to the HoM.
- There was a clear governance process for monitoring and reporting actions and improved collaboration with partner organisations such as the 'Maternity Voices Partnership' with the CCG.
- The maternity service had held engagement meetings and events with the public known as, 'Addressing operational pressures across our maternity services' from 3 July to 13 August.
- One of the improvements since the last inspection was the introduction of 'safety huddles'. These provided a good opportunity for midwives to discuss daily workloads, any problems and review any women who are at increased risk.

The trust was committed to developing a learning culture and had introduced a 'strategic workforce plan'.

Areas for improvement

The trust must:

- Provide an MLU environment at Shrewsbury that is safe (fire safety and infection control) and fit for purpose.
- Ensure that environmental risks are identified and acted on in a timely way.
- Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe.
- Take account of the report from the Royal College of Obstetricians and Gynaecologists (RCOG) review of current practice within maternity services in 2017, when this is released. In respect of the outcome of the report, formulate action plans to improve maternity services.
- Review the processes around escalating women who are at high risk so that these women who present at the MLU/ DAU receive a medical review without delay.
- Review the policy on reduced fetal movements so there is a clear and defined pathway for midwives and sonographers to follow.
- Ensure the HoM has direct access to the board in keeping with recommendations from 'Spotlight on Maternity' 2016.
- Ensure complaints are addressed within the timescale of your complaints policy.
- Ensure NICE operational policies and guidelines are reviewed in date.
- Ensure that, in line with the 'Lone Working & Peripatetic Policy', midwives use the safety devices when working alone.

The trust should:

- Engage with staff about changes and developments and include staff in discussions around these.
- Encourage and facilitate managers and staff to be innovative and to discuss their ideas for positive changes.
- Ensure vision, strategy and trust values are shared with all staff, including how staff roles fit around this.

End of life care

Requires improvement 

Key facts and figures

The trust provides end of life care at two of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,707 deaths from February 2017 to January 2018.

(Source: Hospital Episode Statistics)

The Specialist Palliative Care Team delivers a Monday to Friday (9am to 5pm) service. Severn hospice also provide an out of hours telephone advice service to clinicians.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

End of life care (EoLC) and specialist palliative care services are delivered by two separate teams that worked collaboratively. The EoLC team deliver training to staff across the hospital, lead the champion and volunteer programmes and provide care in the final days and hours of life. The specialist palliative care team (SPCT) provide long-term condition management for patients with life-limiting conditions that are not curable. Both teams are led by clinical nurse specialists with support from a lead consultant for EoLC and a palliative care clinical lead.

EoLC services are centred on the 'Swan' scheme; an acronym for 'Signs, Words, Actions and Needs' as an extension of the national five priorities for end of life care. EoLC resources are branded with the Swan logo, which are embedded in the environment and resources used by all teams involved with care. The Swan scheme is supported by the Swan Fund, which was initiated as the Shrewsbury and Telford Hospital Swan Fund by the EoLC lead facilitator.

End of life and palliative care is delivered across wards and clinical areas with support from a team of EoLC champions and volunteers. There are seven Swan rooms in different areas of the hospital, which offer greater privacy and comfort for patients and relatives.

A mortuary licensed by the Human Tissue Authority is based on site and the team carries out about 800 post mortems per year on behalf of local coroners. The mortuary is equipped for high risk post mortem examinations. The mortuary has a body store with capacity for 89 bodies, a post-mortem room and two viewing rooms. There are nine refrigerated spaces for bariatric bodies and four spaces for frozen storage. There is a baby viewing area and cold room facilities for paediatric bodies.

From April 2017 and March 2018 410 patients were supported for end of life care in the trust. The SPCT dealt with 945 referrals during this period with an average of 79 referrals per month.

There is limited funding and structured support for resources from the trust and a long-standing agreement with a local hospice and support from non-profit community organisations enables the service to continue.

We last inspected end of life care services at the Royal Shrewsbury Hospital in 2016 and rated it as requires improvement overall. At our last inspection in 2016 we found a number of areas for improvement:

- The mortuary team did not routinely monitor temperatures in body storage areas and there were no processes in place to monitor infection control standards.
- Staff did not routinely talk to patients about their preferred place of care and the trust did not record or track this data.

End of life care

- There was a lack of risk recording in the service.
- Mortuary staff decontaminated instruments manually, which presented an increased risk of cross-infection.
- Clinicians did not consistently carry out mental capacity assessments.
- Staff were not up to date with mandatory training.

At this inspection we found the EoLC and SPC teams had addressed some of these issues. However, there had been little progress in improving discussions and documentations of preferred place of care or in the documentation of risks to the service. Practice around mental capacity assessments remained inconsistent. There was substantive evidence of work by end of life and palliative care teams to improve, develop and benchmark the service. However, on-going low capacity and a lack of coherent trust-level strategy meant further development was restricted.

We spoke with 26 members of staff representing a range of roles and responsibilities, including clinical leads, senior nurses and nurse champions, consultants, junior doctors, middle grade doctors, mortuary staff, the bereavement office team, porters and other non-clinical individuals. We reviewed the medical records of 12 patients, looked at trust and regional policies, the minutes of meetings and considered over 65 other items of evidence.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- End of life care (EoLC) and specialist palliative care (SPC) lacked overall coherence, consistency and embeddedness in clinical areas. Services were shared between two teams that were not resourced to provide a seven-day service in line with national guidance. Out of hours support was tenuous, not clearly understood by key staff and lacked a stable, effective governance structure. This was not a reflection of the dedication of the teams of nurses, champions, volunteers and consultants delivering services; their ability to deliver a high standard of care was significantly diluted by the extent of their responsibilities and lack of capacity.
- There were limited audits in place for the service, which meant staff could not accurately benchmark care. Where audits were in place, they did not always establish an accurate assessment of care. For example, the mortuary-based care after death audit could not establish clinical reasons for instances where staff had not fully complied with trust policy.
- The use of the network end of life plan documentation was inconsistent and sporadic and there was no evidence of improvement since our last inspection in 2016. The 2017 audit of this documentation identified areas for significant improvement, including in recording of staff designations, clinical decisions, involvement of patients and factors contributing to end of life treatment plans.
- Nurse and consultant staffing levels did not meet national standards for minimum levels of service. Staff routinely worked cross-site covering large areas of responsibilities and in some cases with more than one job role.
- There were significant shortfalls in governance and quality assurance that were not reflective of the dedication, competence and passion of clinical staff.
- There was limited evidence that membership of a specialist network resulted in improved standards of care or patient outcomes. Internal audits also demonstrated few improvements, including in relation to the preparation of bodies for the mortuary to standards significantly below trust standards.

End of life care

- The EoLC team demonstrated a sustained effort in implementing an improvement action plan that resulted from our last inspection and feedback from peer reviews and input from other organisations. However, there was limited evidence of structured, substantive support from the trust.
- There was a need for broad, sustained and substantial improvements in the consistency, quality, use and availability of patient records and care plans from the general medical teams.
- Standards of practice in relation to the Mental Capacity Act (2005) and mental capacity assessments more generally were highly variable and there was no system in place to effectively correct the poor track record of some clinicians or services. A review of care of patients living with a learning disability who died in the hospital highlighted a series of missed opportunities.
- The trust did not have a system for identifying and tracking incidents specifically relating to this service. The decision to involve the EoLC or SPC teams was subjective and themes in complaints, including around lack of capacity and transport, remained unaddressed.
- Survey and audit results indicated a need for improved consistency and standards in the provision of care after death. EoLC and SPCT teams demonstrated awareness of this and were delivering training to staff to address it.
- The hospital could not meet the trust policy of issuing a medical certificate of cause of death (MCCD) by the end of the certifying doctor's shift or by 12pm the following day. Relatives provided feedback over a six-month period of significant delays in obtaining an MCCD, which were compounded by a lack of capacity in the bereavement office that resulted in lengthy delays in communication.
- Service-level teams, including clinical leads, had demonstrably contributed to the expansion, development and improvement of significant areas of the service. However, this was not reflected in leadership or governance at trust level. As a result staff routinely worked over their capacity, the service could not meet demand and there were gaps in quality and performance assurance.

However, we also found areas of good practice:

- Staff routinely exceeded patient and relative's expectations during the final hours of life and relatives referred to the attention to detail demonstrated by staff. This included facilitating a hospital visit from a patient's pet and escorting a patient to the hospital's tranquil garden in their bed during their final hours.
- Staff delivering EoLC and SPCT services, including front-line staff supporting them, acknowledged the need for sustained and broad improvement. They were participating in the National Audit of Care at the End of Life (NACEL) and the NHS Improvement end of life care hospital improvement project (ELCHIP) as part of a broad strategy to improve standards and quality.
- EoLC and SPC clinical nurse specialists and lead consultants had designed and implemented a wide range of training sessions for staff at all levels of the organisation. This was designed to significantly improve knowledge, understanding and quality of care and reflected the need to substantively improve consistency in practice.
- Staff demonstrated significant and sustained proactivity in securing funding and services from external organisations to improve the service for patients and their relatives. This included in working together to overcome internal challenges and barriers to service development.
- Improvements to the compassion and sensitivity of care and communication shown by staff were evident throughout the service.
- The EoLC lead facilitator was leading an education programme for staff in area nursing homes to provide patients with more options for places of care that would not require a hospital inpatient stay.

End of life care

- EoLC staff had provided resources for each ward to help them in the delivery of care. This included reference checklists, signposting to multidisciplinary services, links national and trust standards and contact details for other organisations. This was in addition to supplying each ward with Swan scheme resources to help provide individualised care to people and reflected the work of the specialist teams to address the lack of capacity by empowering ward teams to deliver more responsive EoLC.
- The EoLC facilitator team played a key role in the advocacy and promotion of end of life services and had arranged health promotion engagement activities to raise the service profile.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Junior doctors demonstrated low levels of knowledge and understanding of the principles of end of life and palliative care. This included a lack of awareness of out of hours escalation, the end of life plan and national standards.
- There was not an effective system in place to ensure syringe drivers were always readily available in the hospital on demand. This was because they could not be tracked if they left the hospital when a patient was discharged to the community. The end of life care (EoLC) lead facilitator had introduced a new process to address this and one clinical unit had bought its own devices. However, staff described instances in which care had been delayed by up to 48 hours because they could not find a syringe driver.
- Specialist palliative care (SPC) nurse staffing cover did not meet the minimum requirements to provide a seven-day service as required by the National Institute of Health and Care Excellence (NICE).
- Consultant staffing levels did not meet the minimum standards of the Royal College of Physicians (RCP) and the trust was yet to implement recruitment to address this.
- Consultant oversight in the decision to limit treatment was variable and audits between 2017 and 2018 demonstrated fluctuating performance.
- Medical records audits found broad inconsistencies and omissions and use of the dedicated end of life plan was sporadic, with a plan used for only 10% of patients who received planned EoLC. An audit specifically of the transfer of patients from the renal service identified instances of missing and delayed records. Programmes of work were in place to address this.
- There were gaps in incident reporting because staff had stopped completing reports for regular occurrences when they felt they did not get feedback. There was also not a system in place to track incidents specifically relating to EoLC or SPC patients and staff in those team had access to records on a subjective basis. Incidents submitted by ward teams demonstrated significant challenges in implementing effective discharge and a poor service from the transport contractor.
- Ward staff found it challenging to obtain on-site out of hours medical support when patients needed a review or a change in medicine. It was not always clear if staff should escalate care and nurses described frequent difficulty in obtaining input from a doctor overnight. Senior staff we spoke with were unaware of this issue.
- Three different audits in 2017/18 identified a need for significant improvements in the frequency, consistency and documentation of clinical reviews of patients. Reviews had taken place in between 40% to 74% of patients in the audits.

However:

End of life care

- EoLC, SPC, volunteer and mortuary teams were 100% up to date with mandatory training. The trust had introduced mandatory EoLC training for all staff with a March 2019 target for completion with significant progress made at the time of our inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew about to apply it.
- Safeguarding processes were embedded and staff worked together in complex cases that involved challenging family dynamics, the coroner and the police. This included when delivering care after death to relatives and preparing medical certificate of cause of death (MCCD) and arranging a post mortem.
- Clinical nurse specialists provided EoLC and SPC services and there had been no use of bank or agency staff.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Prescribers used the national Anticipatory Prescribing in the Dying Patient model to ensure they managed pain relief, anxiety and distress, nausea and vomiting and airway secretions. EoLC and SPC nurse prescribers were working with junior doctors to facilitate more confidence in anticipatory prescribing. Medicines management and prescribing policies were in accordance with established standards set by the British National Formulary, Public Health England and NICE.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- There were no systems in place to identify to staff which patients were being cared for on an end of life care (EoLC) or palliative pathway at any given time. Senior staff said they were aware this meant some patients would not be reviewed by a clinical member of the EoLC or specialist palliative care team (SPCT) and that a better model was needed.
- The trust did not collect data on the proportion of patients who died in their preferred place of care and lack of capacity in EoLC and SPCT teams meant senior staff told us they believed a significant number of patients were missed for home discharge.
- Use of the end of life plan (care plan) remained sporadic and often based on the individual preferences of clinicians. Although we saw sustained improvement work in the acute medical unit, use of the care plan document remained inconsistent elsewhere.
- The most recent mortuary care after death audit noted limited improvements between 2017 and 2018 and found a 23% compliance rate with trust policy. However, the audit design could not capture mitigating circumstances that affected the ability of ward staff to follow trust policy. This meant the mortuary team were not fully assured of the reliability of the results.
- The palliative care service was part of the West Midlands Strategic Clinical Network. Although this provided opportunities for collaborative work, there was limited evidence of benchmarking or quality improvements from audits.
- There was evidence from complaints that clinician knowledge of specific policies and care pathways at the end of life impacted the experience of relatives. This included where communication between clinicians and relatives was unclear and responses from the chief executive indicated the lack of guidance for staff influenced this.

End of life care

- The SPCT provided an urgent referral service for patients who experienced persistent or uncontrolled pain and consultant advice was available 24-hours through an arrangement with a local hospice. However, between February 2018 and August 2018, 74% of relatives who completed the bereavement survey said they felt staff had controlled pain effectively.
- There were gaps in assurance that multidisciplinary teams worked effectively together to assess care in the final stages of life.
- A February 2018 audit found clinicians had documented a mental capacity assessment in only 43% of patients, which was a significant deterioration of standards from the previous audit in 2017. We found significant gaps in practice in relation to mental capacity and adherence to the Mental Capacity Act (2005).

However:

- EoLC facilitators and SPCT had developed an extensive training programme for staff at all grades in the hospital. This included training for clinicians on recognising the end of life and delivering care in line with national standards and training for nurses and healthcare assistants on care after death. The programme included opportunities for junior doctors and the hospital at night team and was designed to significantly improve knowledge and understanding of EoLC across the organisation.
- Between September 2017 and August 2018, 96% of patients referred to the SPCT were seen within 24 hours.
- EoLC was delivered through the Swan scheme, which extended the national Leadership Alliance for the Care of Dying People five priorities for care of the dying patient. This included collaboration with multiple local healthcare stakeholders to implement a comprehensive end of life plan (EOLP) for staff to structure care in the final days and hours of life.
- A rapid referral process was in place for organ and tissue donation through NHS Blood and Transplant and the national referral centre.
- Mortuary services were licensed and regulated by the Human Tissue Authority (HTA) and the team had implemented a successful action plan following a recent compliance inspection.
- The volunteer lead was a member of the Hospice UK national EoLC forum and represented the hospital. This enabled them to benchmark volunteer-led services and hospice referral pathways with national practice and standards.
- EoLC staff supported good nutrition and hydration at the end of life by delivering care in line with the national Taste for Pleasure scheme and through working with dieticians and speech and language therapists to meet individual needs.
- EoLC champions and volunteers worked across the hospital to specific role descriptions and helped provide additional capacity and relief to colleagues and relatives of patients at the end of life.

Is the service caring?

Good 

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

- Staff had expanded the Swan scheme to provide relatives with a more caring, compassionate and sensitive experience. This included the introduction of Swan lanyards for staff to wear to signal they were carrying out a bereavement visit.

End of life care

- The end of life care (EoLC) team and specialist palliative care team (SPCT) had changed the language and terminology used in the delivery of care to be more respectful of the needs of patients and more sensitive to the needs of relatives. This demonstrated attention to detail such as redesigning and renaming the bereavement card and renaming 'difficult conversations' to 'important conversations'. This positivity to the end of life was further demonstrated by the passion and dedication of the EoLC champions and volunteers.
- There was evidence of learning from previous occurrences in the hospital where staff identified opportunities to deliver a more caring service. This resulted in a local non-profit organisation donating children's pyjamas to the hospital for staff to use in place of clinical gowns after an unexpected death.
- Porters had worked with the EoLC teams to develop more compassionate, discreet and sensitive standards for transporting patients to the mortuary after death. New equipment provided greater dignity and could be adapted to any body shape and size.

Is the service responsive?

Requires improvement 

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

- A fast track checklist was in place on each ward to support staff in arranging a rapid discharge to patients' preferred place of care. However, there was limited evidence staff consistently used this and evidence from medical records and relative feedback of missed opportunities.
- Relatives reported discussions with clinical staff about a preferred place of care in only 31% of cases between February 2018 and August 2018. Internal audits also found inconsistent practice in relation to discussions with patients and relatives from clinicians. We were not assured the trust maintained oversight of this process and the EoLC facilitation team and SPCT did not have the resources to ensure a significant change in practice in clinical areas.
- The capacity of the bereavement service was limited. A single member of staff led this service, worked cross-site and was also responsible for the operation of the patient advice and liaison service (PALS). This was reflected in feedback from relatives in the bereavement survey, which indicated they found it difficult to reach the bereavement office by phone.
- Results from the bereavement survey demonstrated areas for improvement in meeting individual needs, including in clinician-led discussions of these and the provision of printed information on end of life to relatives.
- We were not assured the trust maintained accurate records of complaints received about the service or that learning outcomes were identified and embedded.
- Information provided by relatives in the bereavement survey indicated input from clinicians was sometimes delayed or missing.
- Clinicians did not consistently document discussions with relatives about a preferred place of care, although there was evidence of good standards of general involvement with relatives.

However:

- EoLC champions and volunteers on the surgical assessment unit had prepared resources that meant they could establish a Swan room on a mobile, pop-up basis when needed by patients and relatives. They had raised funds themselves and acquired equipment that would provide a homelier environment, including a tea service, mood lighting and toiletries.

End of life care

- The EoLC team had facilitated the instalment of seven Swan rooms. These were private rooms that were decorated to a homelier, less clinical standard to provide comfort to patients in their final hours of life. The rooms were equipped with comfortable furniture for relatives and were more private than bed bays in the wards. The mortuary had been equipped with a dedicate Swan bereavement suite, which represented a significant improvement on previous facilities.
- The EoLC facilitator led an education programme for care home and community care staff, which helped to develop their skills to provide patients with care out of the hospital. This meant patients in the local area had access to more locations where they could comfortably be cared for by trained staff, without the need for a hospital admission.
- The EoLC and bereavement service teams introduced a refreshment voucher scheme for relatives to use in hospital cafes. This provided encouragement for them to take a break from sitting on the ward and provided staff with a tool to provide more substantive support when relatives spent extended periods of time in the hospital.
- Each ward had a supply of Swan boxes that contained individual folders and practical items of comfort for relatives, including a cloth bag for a locket of hair or item of jewellery and forget me not seeds.
- A secluded, peaceful garden was available on site and staff encouraged relatives to use this. Where it was safe for patients to leave the ward staff facilitated this.

Is the service well-led?

Inadequate 🔴 ↓↓

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

- While we saw several areas of improvement delivered by the EoLC facilitators, the mortuary team and the SPCT, there was considerable lack of support and leadership from the trust. There was limited evidence the trust acted on the findings of the end of life care steering group or facilitated timely improvements.
- Although an executive lead for EoLC had been in post for several months, front line staff were unaware of this.
- Staff did not have access to resources or funds to improve the service or increase their capacity to deliver and audit and volunteers had paid for new equipment themselves. This had not resulted in the trust increasing support or reviewing their approach to governance and performance.
- Most staff in EoLC and SPCT services were unclear on the leadership and governance structure of their service. This was underpinned by conflicting information relating to senior nurse leadership in palliative care and a lack of understanding of the role of the executive lead. The trust demonstrated apathy towards the EoLC service and had failed to recognise or account for the risks presented by a significantly under resourced service that could not be consistently delivered every day.
- Feedback from staff about relationships with senior colleagues and the trust more broadly was highly variable and highlighted a need for significant improvement in how the trust engaged with front-line staff. Staff did not always feel listened to or respected and it was not evident the trust valued the EoLC service.
- There were significant gaps in risk and performance management and understanding of these at senior level. Senior staff were unaware more junior colleagues had stopped submitting incident reports due to a perceived lack of action and challenges that were readily spoken about on wards were unknown to senior clinicians. The service lacked a coherent risk register or similar tracking and management process. All of the senior staff we asked about this demonstrated differing knowledge on risks and how these were recorded and addressed.

End of life care

- Staff across the hospital were unclear on the differences between the EoLC and the SPCT. This meant patient referrals and contact for advice was inconsistent and misunderstood.
- An end of life care steering group was established and met quarterly. However, attendance was inconsistent and there was limited evidence the group delivered improvements or substantive development.
- Although governance processes were in place at a local and regional level, there was limited evidence they resulted in improvements to the service and to patient outcomes. Staff involved in the delivery of services said governance was ineffective and action towards improvement was slow.
- The trust did not maintain a tracking record of risks for end of life or palliative care services and staff working in these teams had an inconsistent understanding of the key risks in their service. Where clinical leads had identified risk, it was not evident the trust had a plan to address them.
- Incident reports indicated on-going challenges with effective information management, including the documentation and communication of confidential decisions relating to do not resuscitate (DNAR) authorisations.

However:

- Local leadership in each team was significantly more positive, driven by a need to expand and improve the service. The EoLC facilitation team, mortuary team and SPCT were well respected and staff in clinical areas relied on them for support and guidance.
- EoLC champions and volunteers described consistent, well-structured leadership and support from the EoLC facilitators. Nurses described excellent working relationships that enabled the development of good practice with clinical leads in both services.
- The EoLC team was actively updating the service strategy that had first been implemented in April 2015. This reflected the developments in the service relating to the Swan scheme and their achievements of securing external funding and donations to improve service delivery.
- There was an overriding culture of passion and enthusiasm amongst staff in all areas to deliver care within the principles of the Swan scheme. Resources were used effectively and in the best interests of patients and their families and EoLC champions and volunteers facilitated the positivity around this scheme in all areas in which they worked.
- SPCT and EoLC meeting minutes demonstrated staff were resourceful and resilient in overcoming barriers to service delivery and development.
- A new patient experience panel was in the process of being formed, with an updated remit and purpose following learning from the previous format.

Outstanding practice

The end of life care (EoLC) team and bereavement service had introduced a bereavement visit lanyard for staff to wear when accompanying relatives on bereavement visits. This was implemented as learning from an incident in which a member of staff accompanying a bereaved parent was approached by a colleague inappropriately because they had not identified the nature of the situation. The new lanyard was discreet and branded with the Swan logo, which indicated to staff that they should not interrupt the visit.

There was a demonstrable, sustained drive to improve the sensitivity of the delivery of care by all staff in the hospital. This included a review of the language used to describe meetings and bereavement cards and the supply of more personal clothing to replace standard-issue hospital items.

EoLC champions and volunteers had attended 'touch training' that enabled them to provide hand-holding therapy during the final hours of life. This helped to reduce anxiety and had received positive feedback from relatives.

A photographer was available on demand to take memento photographs of hand-holding in the last moments of a patient's life. Staff said relatives appreciated this service as it helped them to focus on the tranquillity of the final moments. The photographer provided photographs within one hour of taking them and delivered them if relatives had left the hospital by the time they were ready.

There was a significant drive from staff to engage colleagues, the trust and the public in discussions of EoLC. They delivered a well-attended Dying Matters week event, issued certificates of achievement for ward staff who receive compliments for their work and worked with the Transforming Care Institute to embed discussions of EoLC into ward discussions.

The rust had recognised teams in the acute medical unit and in the emergency department with awards for their work to improve the care and experience of patients at the end of life.

Areas for improvement

The trust must:

- Ensure staff are supported to report incidents.
- Review staffing levels against Royal College of Physicians guidance.
- Ensure doctors out of hours have the capability and confidence to review patients at the end of life, including through prescribing.
- Ensure records are properly completed and used by appropriate staff including EOLP.
- Ensure governance processes are fit for purpose, support those responsible for service delivery and result in improved safety and effectiveness.

The trust should:

- Review service provision against National Institute of Health and Care Excellence guidance.
- Ensure junior doctors continue to be engaged in training and have the opportunity to request more advanced training where needed.
- Review the governance structures in place to ensure they are fit for purpose, result in meaningful change and result in timely progress.
- Review the results of the bereavement survey to identify trends and key issues, as outlined in our evidence appendix.
- Review staffing levels for the bereavement office.
- Ensure data is collected with regards to patients' preferred place of care, including when this has been offered and when it has been achieved.
- Establish a more robust system of identifying end of life care patients.
- Embed the use of the end of life plan to improve patient experience in the last days and hours of their life.
- Fast track discharges should be monitored and audited.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

The inspection was led by Victoria Watkins, Head of Hospital Inspection and Zoe Robinson, Inspection Manager.

The team for the well led review, core services and unannounced inspections included 19 inspectors, two of which were mental health inspectors, one pharmacist inspector and 15 specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.