Shrewsbury and Telford Hospital NHS Trust

Inspection report

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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 trust quality rating	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Inadequate**

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.

Summary of findings

Background to the trust

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford.

The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019.

Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services.

The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

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

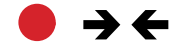
Hospital sites at the trust

A list of the trust's acute hospitals is below. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

- Princess Royal Hospital - Apley Castle, Telford, Shropshire TF1 6TF
- Royal Shrewsbury Hospital - Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XQ

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Inadequate 

What this trust does

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

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.

What we inspected and why

We carried out a core service inspection and well led review. We visited both hospitals and inspected the following core services between 12 to 20 November 2019:

Princess Royal Hospital (PRH):

- Urgent and emergency care.
- Medical care.
- Surgery.
- Maternity.
- Children and young people.
- End of life care.
- Outpatients.

Royal Shrewsbury Hospital (RSH):

- Urgent and emergency care.
- Medical care.
- Surgery.
- End of life care.
- Outpatients.

We carried out a well led review on 8 to 10 January 2020. To assess if the organisation was well-led, we interviewed the members of the board, the executive team and held a focus group with non-executive directors and a range of staff across the hospital. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders. The well-led review team comprised of a head of hospital inspection, inspection manager, inspector, pharmacy specialist, an executive reviewer from another NHS trust, two special clinical advisors with significant experience of governance and NHS trust boards and NHS England/improvement.

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

What we found

Overall trust

Summary of findings

Our rating of the trust stayed the same. We rated it as inadequate because:

- The safe, effective, responsive and well led key questions were all rated as inadequate.
- The caring key question went down to requires improvement.
- Royal Shrewsbury Hospital was rated requires improvement.
- The Princess Royal Hospital was rated as inadequate.

Are services safe?

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

- Princess Royal Hospital (PRH) was rated as inadequate for safety overall.
- Core services urgent and emergency care and medical care at PRH were rated as inadequate for safety.
- Outpatients at PRH was rated as good for safety.
- Surgery, maternity, services for children and young people and end of life care at PRH were all rated as requires improvement for safety.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for safety overall.
- Urgent and emergency care at RSH was rated as inadequate for safety.
- All other core services were rated as requires improvement.

Are services effective?

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

- Princess Royal Hospital (PRH) was rated as inadequate for effective overall.
- Core services urgent and emergency care and medical care at PRH were rated as inadequate for effective.
- Maternity at PRH was rated as good for effective.
- We do not rate outpatients for effectiveness.
- All other core services were rated as requires improvement for effective at PRH.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for effective.
- Urgent and emergency care at RSH was rated as inadequate for effective.
- We do not rate outpatients for effectiveness.
- All other core services at RSH were rated as requires improvement.

Are services caring?

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

- Both hospitals were rated as requires improvement for caring.
- Surgery, maternity and outpatients at Princess Royal Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.
- End of life care and outpatients at Royal Shrewsbury Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.

Summary of findings

Are services responsive?

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

- Princess Royal Hospital (PRH) was rated as inadequate for responsive overall.
- Core services urgent and emergency care and children and young people at PRH were rated as inadequate for responsive.
- Outpatients at PRH was rated as good for responsive.
- The other core services inspected at PRH were rated as requires improvement.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for responsive.
- Urgent and emergency care at RSH was rated as inadequate for responsive.
- All other core services inspected at RSH were rated as requires improvement.

Are services well-led?

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

- Royal Shrewsbury Hospital was rated as requires improvement for well led.
- Princess Royal Hospital was rated as inadequate for well led overall.
- Overall, the trust was rated as inadequate for well led.

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 some areas, see below for more information.

Areas for improvement

We found areas for improvement including 92 breaches of legal requirements that the trust must put right. We found 75 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 service quality.

Action we have taken

We issued nine requirement notices to the trust. We also took urgent action and issued eight new conditions of registration and varied two existing conditions of registration as well as issuing a section 29 A warning notice.

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.

Summary of findings

Outstanding practice

We found examples of outstanding practice in:

In Outpatients at PRH:

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.
- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

In Surgery at RSH:

- We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust must take to improve:

At trust Well led level:

- Ensure there are effective governance systems and process in place to effectively assess, monitor and improve the quality and safety of services. Regulation 17 (1): Good governance.
- Ensure there are effective systems and process to assess monitor and mitigate risks. Regulation 17(2): Good governance.
- Ensure there is consistent use and completion of the incident investigation form for serious incidents, that learning is clearly identified, actions developed, and impact reviewed. Regulation 17(1): Good governance.
- Ensure the backlog of incidents awaiting review is reduced. Regulation 17(1): Good governance.
- Ensure that robust processes are in place to confirm all directors are fit and proper for the role. Regulation 5: Fit and proper persons – directors

The trust SHOULD take action to:

- Progress the plans to review the vision, strategy and values to promote high quality care.
- Consider how leaders can be more visible to staff, with recognition from staff of this visibility.
- Develop and support a culture in which staff feel supported, respected and valued.
- Consider a board level lead for mental health.

Summary of findings

- Finalise and implement the digital strategy so that information technology systems are used effectively to accurately monitor and improve the quality of care.

In Urgent and emergency care at PRH:

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.
- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.
- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.
- Ensure they 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. Regulation 17 (1) (2) (a): Good governance.
- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.
- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.
- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.
- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

In Medical care at PRH:

The service MUST take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.
- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.
- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.
- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.
- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.

Summary of findings

- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.
- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.
- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.
- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

In Maternity at PRH:

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.
- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.
- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.
- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.
- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.
- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

In Children and Young People care at PRH:

The service MUST take action to:

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.
- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.
- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

In End of life care at PRH:

The service MUST take action to:

Summary of findings

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

In Urgent and emergency care at RSH:

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.
- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.
- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.

Summary of findings

- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.
- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.
- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.
- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.
- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.
- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.
- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.
- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.
- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.
- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.
- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

In Medical care at RSH:

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.
- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.

Summary of findings

- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.
- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.
- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.
- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.
- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

In Surgery at RSH:

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.
- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.
- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.
- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.
- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.
- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

In End of life care at RSH:

The service MUST take action to:

Summary of findings

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

In Outpatients at RSH:

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.
- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

Actions the trust should take to improve:

In Urgent and emergency care at PRH:

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.
- Review departmental risk registers to ensure actions are updated in a timely manner.
- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.
- The service should obtain an observation policy and a robust restraint policy in place.

In Medical care at PRH:

The service SHOULD take action to

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.
- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.
- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

In Surgery at PRH:

The service SHOULD take action to:

Summary of findings

- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.
- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.
- Continue to try and improve flow through theatre and reduce the number of cancelled operations.
- Continue to try and improve the admitted pathway referral to treatment times.
- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.
- Make improvements in the National Hip Fracture Database audits outcomes.

In Maternity care at PRH:

The service SHOULD take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.
- The trust should ensure all staff complete accurate documentation around CTG monitoring.
- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.
- The trust should ensure that all midwives have an annual appraisal.

In Children and Young People care at PRH:

The service SHOULD take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.
- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

In End of life care at PRH:

The service SHOULD take action to:

- The service should carry out plans to employ more than one whole time equivalent (WTE) chaplain.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.

The service should undertake audits for pain or symptom control for end of life care patients.

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.
- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.
- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.

Summary of findings

- Monitor that medical staff complete patient records in a clear and legible way.
- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.
- Consider ways to improve staff engagement with senior leaders and the executive team.

In Urgent and emergency care at RSH:

The trust SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.
- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.
- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.
- The service should continue to work with commissioners to improve ambulance handover times.
- The service should continue to embed local initiatives aimed to improve sepsis care.
- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.
- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.
- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.
- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.
- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.
- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.
- The service should explore how to effectively display patient safety information within the ED.
- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).
- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.
- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.
- The service should continue with the implementation of a suitable competency tool for staff working.

In Medical care at RSH:

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.
- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

Summary of findings

In Surgery at RSH:

The service SHOULD take action to

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.
- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.
- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.
- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.
- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.
- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.
- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.
- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.
- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.
- The service should consider reviewing management staffing out of hours to support the provision of seven day working.
- The service should review the process for providing agency staff with immediate access to electronic records and systems.

In End of life care at RSH:

- The service should carry out plans to employ more than one whole time equivalent (WTE) chaplain.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

In Outpatients at RSH:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.
- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.

Summary of findings

- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.
- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.
- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems.
-

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 was the same as the previous inspection. We rated it as inadequate because:

- Due to the instability of the board and the significant number of issues to address, leaders did not have the necessary capacity and capability to lead effectively. There was not a stable executive leadership team, with several interim members. There were few examples of leaders making a demonstrable impact on the quality or sustainability of services, indeed the quality in some areas had deteriorated. Leaders were not always visible and approachable to staff.
- The trust's strategy, vision and values were developed in 2016 and had not delivered on all the objectives set. Progress against delivery of the strategy and plans was not consistently or effectively monitored or reviewed and there was little evidence of progress. Leaders at all levels were not always held to account for the delivery of the strategy. Staff informed us they did not always observe or experience members of the executive team displaying the trust values in their behaviours.
- There was an improving understanding of the importance of culture, however, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. Staff reported the culture was top-down and directive. Staff told us about high levels of bullying, harassment, discrimination or violence, and the organisation was not taking adequate action to reduce this. When staff raised concerns, they were not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. There was improving attention to staff development and improving appraisal rates.
- The arrangements for governance and performance management were not always fully clear and did not always operate effectively. Staff were not always clear about their roles, what they were accountable for, and to whom. Governance systems were ineffective to ensure quality services were provided.
- Although the trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected these were not working effectively.
- The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders recognised the quality f data was poor however they were relaying on and taking assurance from this data. Information was used mainly for assurance and rarely for improvement. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not always robust.

Summary of findings

- Staff felt they were not listened to and were sometimes fearful to raise concerns or issues, these were issues at the last inspection.
- Improvements were not always sustained. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance. Systems lacked maturity and senior leaders recognised this.

However,

- Required data or notifications were submitted to external organisations.
- The trust engaged with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations.

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 ➔➔ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ➔➔ Apr 2020	Inadequate ➔➔ Apr 2020

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
Royal Shrewsbury Hospital	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ↑ Apr 2020
Princess Royal Hospital	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Overall trust	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020

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 Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Medical care (including older people's care)	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Surgery	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
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
End of life care	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020
Outpatients	Requires improvement Apr 2020	Not rated	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Overall*	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ↑ Apr 2020

*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 Princess Royal Hospital.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ➔➔ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ➔➔ Apr 2020	Inadequate ➔➔ Apr 2020
Medical care (including older people's care)	Inadequate ↓ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ↓ Apr 2020
Surgery	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Good ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020
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	Requires improvement ↑ Apr 2020	Good ↑ Apr 2020	Good ➔➔ Apr 2020	Good ➔➔ Apr 2020	Requires improvement ➔➔ Apr	Requires improvement ➔➔ Apr
Services for children and young people	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020
End of life care	Requires improvement ➔➔ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ➔➔ Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ➔➔ Apr 2020
Outpatients	Good Apr 2020	Not rated	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Overall*	Inadequate ➔➔ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ➔➔ Apr 2020	Inadequate ➔➔ Apr 2020

*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

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Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Princess Royal Hospital has 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

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

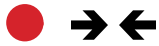
Summary of services at The Princess Royal Hospital

Inadequate ● →←

Our rating of services stayed the same. We rated it them as inadequate because:

- The safe key question remained as inadequate.
- Effective key question went down to inadequate.
- Caring key question went down to requires improvement.
- Responsive went down to inadequate.
- Well led key question remained as inadequate.

Urgent and emergency services

Inadequate 

Key facts and figures

Details of emergency departments and other urgent and emergency care services at this trust:

- Royal Shrewsbury Hospital emergency department.
- Princess Royal Hospital emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a major's unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department. Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics. The internal layout of the Emergency Department (ED) comprises of a main waiting area. Within this area there were two hatches; one where patients book in and see a streaming nurse (for minor injuries); the other is used for all 'walk in' patients to book in with reception staff. A triage room leads off the main waiting room. Within the treatment areas there 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 to sit and wait further assessment. The other 'fit to sit' cubicle was a bed where patients could be examined individually if necessary. There was also a separate treatment room which was used for patients with communicable infections. If this room was in use, infectious patients were transferred to 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. A further 'Swan' room was also used to locate patients who were at the end of life in the department.

Summary of this service

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

- Managers did not make sure that everyone completed their mandatory training. Not all staff had completed their safeguarding training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.
- The design and use of facilities for patients were not designed to keep people safe. Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor. The service had variable rates around vacancy and bank usage for their staff. The service sometimes had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff sometimes kept detailed records of patients' care and treatment. Records were sometimes clear, up-to-date. The service sometimes used systems and processes to safely prescribe, administer, record and store medicines.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers sometimes ensured that staff followed guidance and were kept up to date on evidence-based practice. Patient outcomes were worse than national averages. The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.

Urgent and emergency services

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Patients were not always respected of their privacy and dignity or considered their individual needs. Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.
- The service sometimes planned and provided care in a way that met the needs of local people and the communities served. The trust sometimes worked with others in the wider system or local organisations to plan care. The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services. Patients 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.
- Leaders did not always understand or manage the priorities and issues the service faced. The trust did not always 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. The department did not always have effective systems for identifying risks. The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.
- The department had not learnt from some of the findings from the last inspection.

Is the service safe?

Inadequate  

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

- Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor.
- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Managers did not make sure that everyone completed their mandatory training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.
- Not all staff had completed their safeguarding training.
- The design and use of facilities for patients were not designed to keep people safe.
- Managers investigating incidents did not always share lessons learned with the whole team or the wider service.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Urgent and emergency services

- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- Managers reviewed staffing levels and skill mix and gave locum staff a full induction.
- The service had nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were stored securely and easily available to all staff providing care.
- The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.

Is the service effective?

Inadequate 

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

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always ensure that staff followed guidance and were kept up to date on evidence-based practice.
- Patient outcomes were worse than national averages.
- The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to improve outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 

Urgent and emergency services

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

- Patients were not always respected of their privacy and dignity or considered of their individual needs.
- Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.

However,

- Staff treated patients with compassion and kindness.
- Staff understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Inadequate 

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

- Patients 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.
- The service did not always plan and provide care in a way that met the needs of local people and the communities served. The trust did not always work with others in the wider system or local organisations to plan care.
- The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services.

However,

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Staff coordinated care with other services and providers.

Is the service well-led?

Inadequate 

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

- Leaders did not understand or manage the priorities and issues the service faced.
- 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.
- The service did not have effective systems for identifying risks.

- The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.
- The service had not learned from some of the findings from the last inspection

However,

- Leaders had the skills and abilities to run the service.
- Local leadership were visible and approachable in the service for patients and staff. Local leadership supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued by local leaders. They were focused on the needs of patients receiving care. The department provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns.
- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff engaged with patients and staff.
- All staff were committed to continually learning.

Areas for improvement

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.
- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.
- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.
- Ensure they 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. Regulation 17 (1) (2) (a): Good governance.
- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.
- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.
- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

Urgent and emergency services

- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.
- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.
- Review departmental risk registers to ensure actions are updated in a timely manner.
- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.
- The service should obtain an observation policy and a robust restraint policy in place.

Medical care (including older people's care)

Inadequate 

Key facts and figures

The trust's medical care service provides care and treatment for specialties including cardiology, gastroenterology, neurology, oncology, respiratory medicine and stroke medicine.

(Source: Routine Provider Information Request AC1 - Acute context)

The medical care service at Princess Royal Hospital provides care and treatment for specialties including cardiology, gastroenterology, neurology, respiratory medicine and stroke medicine.

The hospital has 211 medical inpatient beds located across 11 wards and units:

The trust had 77,043 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 30,006 (38.9%), 571 (0.7%) were elective, and the remaining 46,466 (60.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,878
- Gastroenterology: 20,301
- Clinical oncology: 12,649

(Source: Hospital Episode Statistics)

Our inspection of this service was unannounced (the trust did not know we were coming). During our inspection we visited all areas where medical services were delivered from. We spoke with staff of all levels including health care assistants, nurses, ward manager, matrons, junior doctors, registrars and consultants. We spoke with patients and their families about the care and treatment they had received at the trust. During our inspection we also reviewed patient documentation and requested further evidence from the trust.

Summary of this service

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

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.
- We had concerns about the administration of rapid tranquilization.
- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff did not always report incidents.

Medical care (including older people's care)

- Distress in the open environment was not always handled discreetly.
- The service did not always consider of patients' individual needs and preferences.
- Not all staff felt respected, supported and valued.
- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

However:

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received.

Is the service safe?

Inadequate 

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

- The service provided mandatory training in key skills to all staff. However, not everyone had 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 training on how to recognise and report abuse.
- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Not all equipment was well maintained and ready for use or used safely.
- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.
- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.
- We had concerns about the administration of rapid tranquilisation.

Is the service effective?

Inadequate 

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

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

- The service did not make sure all staff were competent for their roles.
- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieved good outcomes for patients.
- Not all key services were available seven days a week to support timely patient care.

However:

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Is the service caring?

Requires improvement 

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

- Staff did not always treat patients with compassion and kindness or respect their privacy and dignity.
- Distress in the open environment was not always handled discreetly.

However:

- Staff provided emotional support to patients, families and carers.
- Staff supported and involved patients, families and carers to understand their condition and make 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 service did not always consider of patients' individual needs and preferences.

However:

- The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- Most people could access the service when they needed it and received the right care promptly.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received.

Medical care (including older people's care)

Is the service well-led?

Inadequate 

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

- Not all issues and priorities to the service were understood.
- Not all staff felt respected, supported and valued. Staff told us the culture was not always supportive of raising concerns without fear.
- Although there were governance systems in place these were not operating effectively to improve the quality of services.
- Although there were systems in place to mitigate risks, these were not working effectively. Not all risks to the service had been identified and escalated with actions to reduce their impact, risk identified at previous inspections had not been resolved.
- All staff were committed to continually learning and improving services however not all actions taken had improved patient care.

However:

- Leaders had the integrity, skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services

Areas for improvement

The service Must take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.
- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.
- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.
- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.
- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.
- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.
- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.

Medical care (including older people's care)

- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.
- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

The service Should take action to:

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.
- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.
- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

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 surgery core service at Princess Royal Hospital includes breast surgery, ENT, maxilla-facial surgery and planned and emergency orthopaedics. In addition, the hospital accepts all head and neck emergency patients referred by GPs and admitted from the emergency departments at both the trust's acute sites.

Princess Royal Hospital has eight operating theatres (excluding the two maternity operating theatres which are not relevant to this core service) and 106 surgical inpatient beds located across four wards and units.

The trust had 31,414 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 12,930 (41.2%), 3329 (10.6%) were elective, and the remaining 15,155 (48.2%) were day case.

We inspected the service from the 18 to 20 of December 2019. As part of the inspection we visited the following areas:

- Day Surgery Unit
- Ward 4 (trauma and orthopaedics)
- Ward 8 (trauma and orthopaedics)
- Ward 17 (head and neck/elective orthopaedics)
- Day surgery theatres
- Main theatres
- Theatre recovery

During the inspection we spoke with 14 patients, 51 staff and reviewed 12 patient records and 17 prescription charts. We reviewed policies, performance information and data about the surgical service.

The service was last inspected in 2018. At the last inspection it was rated as requires improvement overall and for safe, effective, responsive and well led. Caring was rated as good.

Summary of this service

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

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.
- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.
- There was frequent wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)

Surgery

- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.
- From August 2018 to July 2019 the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.
- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.

However,

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

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

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.
- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.
- There was frequent wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)
- Prescribers did not always write separate prescriptions for medicines (paracetamol) that could be given by either the oral or intravenous route. Nurses sometimes failed to record the actual dose administered for pain relief medicines when they were prescribed as a variable dose.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Surgery

- The service mainly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well**.**
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 

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

- Although there were examples of using the findings to make improvements this was not consistent in all audits and in the National Hip Fracture Database showed a deterioration.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- 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 needs.
- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Surgery

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Good 

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make 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:

- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.
- From August 2018 to July 2019, the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.

However,

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement 

Surgery

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

- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.
- Inaccurate marking of surgical sites and inaccurate recording on consent forms and theatre lists was not on the risk register. Although the head of quality and safety was aware of the issue, we were not assured that this risk had senior management oversight and regular review.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, and the public to plan and manage services.
- All staff were committed to continually learning and improving services.

Areas for improvement

The service should take action to:

- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.
- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.
- Continue to try and improve flow through theatre and reduce the number of cancelled operations.
- Continue to try and improve the admitted pathway referral to treatment times.
- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.
- Make improvements in the National Hip Fracture Database audits outcomes.

Maternity

Requires improvement  

Key facts and figures

The trust has 70 maternity beds. Of these beds 53 are located within the consultant-led maternity unit at Princess Royal Hospital:

Ward 21, Postnatal, 23 beds.

Ward 22, Antenatal, 17 beds.

Ward 24, Delivery suite, 13 *en-suite* delivery rooms.

The delivery suite has a pool room and includes the two maternity theatres and recovery area.

The Wrekin midwife-led unit is situated in the grounds of the Princess Royal Hospital. The unit has 17 beds. These include four birthing rooms, one with a birthing pool. Postnatal care is provided in four bed bays. Many women who have had a baby in the consultant unit transfer to the Wrekin Unit for postnatal care.

We spoke with 46 members of staff including midwives, doctors, maternity support workers, sonographers, ward clerks and housekeepers. We also spoke with seven women and four of their relatives. We observed interactions between women and staff, considered the environment and looked at 36 women's care records and six prescription records. We also reviewed other documentation from stakeholders and nationally published data for the trust.

The midwife-led unit at Royal Shrewsbury Hospital and the Bridgnorth, Ludlow, and Oswestry maternity units are currently closed to inpatients, because of non-compliance with building regulations.

The trust also provides antenatal and postnatal care from community bases at Whitchurch and Market Drayton.

The trust's maternity service provides antenatal, postnatal and intrapartum obstetric and maternity care that includes scanning, early pregnancy assessment and triage.

The trust noted that midwifery-led care in the area is currently being reviewed by Shropshire, Telford & Wrekin Clinical Commissioning Group in line with the National Maternity Review (Better Births) 2016.

(Source: Trust Provider Information Request – Sites tab and Acute context; trust website)

From January 2018 to December 2018 there were 4,348 deliveries at the trust.

Summary of this service

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

We rated effective, caring and responsive as good. Safe and well led were rated as requires improvement.

- Staff did not always complete training in key skills. Staff did not protect patients from abuse in line with trust policy staff were not asking about domestic abuse in line with trust policy. Safety incidents were not always graded and reported incidents correctly according to harm. Staff did not always ensure medical staff assessed risks to patients. The service did not always ensure women received one to one care in labour. Staff did not always complete all risk assessments.

Maternity

- Leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. Leaders and teams did not always use systems to manage performance effectively. Not all performance data was formatted in line with national guidance. Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

However,

- They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers mostly monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

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

- The service provided mandatory training in key skills to all staff, however the trust target for attendance at training was not met by the service. Midwifery staff were not compliant with all mandatory update requirements.
- Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. However, not all staff identified and quickly acted upon women and their babies at risk of deterioration.
- The service made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development. However, managers did not appraise all staff's work performance.
- Eligibility of medical staff for safeguarding children level 3 training was low.

However:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean, however we found minute traces of body fluids were evident on one chair and a bed.

Maternity

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service, however incidents were not always graded correctly according to the level of harm. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave women 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 women's religious, cultural and other needs.
- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave women practical support and advice to lead healthier lives.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.
- However, managers did not appraise all staff's work performance.

However,

Maternity

- The service generally made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development.

Is the service caring?

Good ➔➔

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

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment. Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- Women could usually access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards. However, discharge from the triage unit was not always in line women's care plans.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Is the service well-led?

Requires improvement ➔➔

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

- Leaders did not have the skills and abilities to effectively lead the service and did not always operate effective governance processes throughout the service and with partner organisations.

- Leaders did not have full oversight of the risks that were identified during the inspection with regard to poor risk assessments, one to one care, domestic abuse, carbon monoxide screening.
- Leaders and teams did not always identify relevant risks within the service and therefore did not identify actions to reduce their impact.

However,

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.
- The maternity service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards. Staff understood their responsibilities regarding accessing and storing confidential information
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Areas for improvement

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.
- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.
- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.
- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.
- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.
- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

Maternity

The service should take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.
- The trust should ensure all staff complete accurate documentation around CTG monitoring.
- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.
- The trust should ensure that all midwives have an annual appraisal.

Services for children and young people

Requires improvement 

Key facts and figures

The trust has 36 paediatric inpatient beds located on Ward 19 at Princess Royal Hospital. Children up to the age of 16 years can be admitted to the children's ward. Once a patient reaches their sixteenth birthday they will be admitted to an adult ward.

The hospital also has a children's assessment unit consisting of eight assessment beds where children are assessed to determine if they require admission to the children's ward or treatment prior to discharge home. The unit is open 24 hours seven days a week.

The hospital's neonatal unit (Ward 23) has 23 cots.

There is a medical day unit at Royal Shrewsbury Hospital for children with long term conditions requiring outpatient assessment and diagnostics. This service is open from 9am to 5pm Monday to Friday.

The trust had 9,068 spells in its services for children and young people from March 2018 to February 2019.

Emergency spells accounted for 91% (8,275), 7% (620) were day case and the remaining 2% (173) were elective

During our inspection we spoke with seven patients and their families, we checked 10 pieces of equipment, seven sets of patient records and seven prescription charts.

Summary of this service

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

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.
- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.
- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.
- The design, maintenance and use of facilities, premises and equipment kept people safe, however some environments did not follow national guidance. Children and young people were not separated from adults in the day surgery and the main theatre recovery areas.
- The service did not always make sure staff were competent for their roles. Staff were not trained to care for children and young people with mental health needs, learning disabilities or autism.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

Services for children and young people

- The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care. The service did not have a transition lead nor a transition policy to support children and young people moving into adult services. There were very limited facilities to support the needs of children and young people with additional needs.
- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.

However,

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Is the service safe?

Requires improvement 

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

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.
- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.
- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.

However,

- The design of the environment, maintenance and use of facilities, premises and equipment kept people safe.
- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.

Services for children and young people

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 

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

- The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

However,

- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for children, young people and their families' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.

Services for children and young people

- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions.

Is the service caring?

Requires improvement  

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

- Patients with additional needs including mental health, learning disabilities and autism were not always treated equally. For example, we saw and were told patients with mental ill health were not permitted to mix.

However,

- Staff provided emotional support to children, young people and their families to minimise their distress.
- Staff supported and involved most children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- Staff treated most children, young people and their families with compassion and kindness.

Is the service responsive?

Inadequate 

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

- The service did not always plan and provide care in a way that met the needs of local people and the communities served.
- Staff did not always make reasonable adjustments to help children, young people and their families access services or coordinate care with other services and providers. Young people over 16 were not generally offered access to children and young people's wards.
- The service did not have training and systems in place to respond to a gap in CAMHS support at weekends and evenings.
- The service did not have a transition lead nor a transition policy to support children and young people moving into adult services.
- There were very limited facilities to support the needs of children and young people with additional needs.

However,

- The service was mostly inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.
- The service did not always promote equality and diversity in daily work and provide opportunities for career development. The service leads had not sought further development for staff working with patient with additional needs such as mental health, autism or learning disabilities, therefore did not always promote equality and diversity.
- Staff were unaware of the service vision and strategy and were not involved in the creation of them.
- Leaders operated governance processes throughout the service and with partner organisations, however they were not all effective as they were not yet embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Systems that managed performance were effective. Leaders and teams had identified and escalated most relevant risks and issues and identified actions to reduce their impact. Leaders and teams had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated, and all patient records were stored securely.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

The service Must take action to:

Services for children and young people

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.
- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.
- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

The service should take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.
- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

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 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, three ward managers, five ward sisters, four nurses, two healthcare assistants, the head of pathology, the mortuary manager, the bereavement manager, the chaplain, two administrators, three porters, three patients and four family members. We also reviewed 11 care records.

Summary of this service

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

- We rated all five key questions as requires improvement.

Is the service safe?

Requires improvement 

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

- he service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.
- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff used infection control measures when visiting patients on wards and transporting patients after death.

End of life care

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- Records were stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 

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

- The service did not audit pain and symptom control, or time taken for fast track audits.
- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.
- 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 needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Requires improvement 

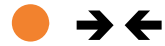
Our rating of caring went down. We rated it as requires improvement because:

- We found in the children's viewing room the bedding for the children's cot and the teddy bear placed in the viewing cot were visibly dirty. There were also two bassinets of different sizes for the viewing of babies. Each bassinet had a

silk lining, both bassinettes' linings were dirty. One of the bassinet's silk lining had what appeared to be a large dried liquid stain. We asked the mortuary staff member when the bedding was last cleaned, we were advised that it was not known if the bedding had ever been cleaned. We escalated this to the trust, who immediately replaced the bedding in the viewing cot and bassinets

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

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

- The service did not audit waiting times from referral to achievement of preferred place of care and death.

However;

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint

Is the service well-led?

Requires improvement 

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

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.
- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.
- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

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

End of life care

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Areas for improvement

The service Must take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

The service should take action to:

- The service should carry out plans to employ more than one whole time equivalent (WTE) chaplain.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Good

Key facts and figures

Outpatient services at Shrewsbury and Telford NHS Trust are provided mainly at The Princess Royal hospital and the Royal Shrewsbury hospital sites, with a small number of services within the community. Across the trust, outpatients services is managed by scheduled and unscheduled care groups and various specialties. The Scheduled Care Group manages a large proportion of the outpatient activity and associated nursing support across both main trust sites and also at the satellite sites. The Unscheduled Care Group manages all the musculoskeletal services which provides outpatients appointments for the fracture clinic and plaster room. The service is for men, women and children of all ages. Most children's outpatients appointments take place in an area attached to the children's wards which is separate to the main outpatients department. Children are seen alongside adults for the specialities of ear, nose and throat (ENT) and fracture clinics which are located in the main outpatients areas. Specialties using main outpatients include respiratory, renal, cardiology, vascular, urology, breast, gastroenterology, general surgery, medicine and medical specialties. All other outpatient departments are specialty managed. These include:

- Ophthalmology.
- Ear, nose and throat (ENT).
- Maternity.
- Dental.
- Endoscopy.

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the Trust's activity through the main outpatients department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings. Outpatients is managed by the outpatients matron, outpatients manager and sisters.

During our inspection we:

- visited the main outpatient departments, phlebotomy, pre-operative assessment service, audiology, and the outpatient therapy clinics including physiotherapy and occupational therapy.
- spoke with 12 relatives and 18 patients.
- spoke with 42 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and triumvirate managers.
- looked at six sets of patient records in detail and observed several more.
- observed interactions between patients, relatives and staff.
- observed four patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Outpatients

Summary of this service

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- The service had enough nursing staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed most risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Most people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- The service did not always have enough medical staff provided clinic appointments for some specialities quickly enough.
- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. Remedial action for this was in progress. The service controlled infection risk well in all other areas.
- Not all patient consultation records were clear and fully legible.
- Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff conducting MCA assessments. Staff were not up to date with (MCA) training. The trust had a plan to remedy this.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

Is the service safe?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

Outpatients

- The service provided mandatory training in most key skills to all staff and made sure everyone completed it. This was an improvement since our last 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 how to apply it.
- The service controlled infection risk well in almost all areas. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing, medical and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was an improvement since our last inspection. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

However,

- Staff were not up to date with mental capacity act (MCA) training. The trust had a plan to remedy this. Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff to conduct MCA assessments during the consultation.
- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. However, the service controlled infection risk well in all other areas.
- Not all handwritten patient records were clear and legible. However, detailed consultation outcomes were typed and added to the record after the appointment.

Is the service effective?

Not sufficient evidence to rate

We do not currently provide a rating for Effective. We found that:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and when they were delayed for a long time in the department.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Outpatients

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Most staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

However,

- Key services were not available seven days a week to support timely patient care. However, some clinics were provided at weekends to meet patient needs.
- Staff did not always fully support patients to make informed decisions about their care and treatment. Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, they followed national guidance to gain patients' consent.

Is the service caring?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good

This is the first time we have rated outpatients separately from diagnostic imaging.

- We rated it as good because:
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers

Outpatients

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However,

- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

Is the service well-led?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a strategy developed with all relevant stakeholders. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress
- Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Most staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Most staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However,

- Staff did not feel valued or respected by senior leaders in the trust's executive team.

Outstanding practice

We found areas of outstanding practice;

Outpatients

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.
- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

Areas for improvement

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.
- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.
- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.
- Monitor that medical staff complete patient records in a clear and legible way.
- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.
- Consider ways to improve staff engagement with senior leaders and the executive team.

Royal Shrewsbury Hospital

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Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres. The trust employed 6,146 staff as of July 2019. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

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

Summary of services at Royal Shrewsbury Hospital

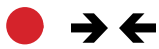
Requires improvement 

Our rating of services improved. We rated it them as requires improvement because:

- The safe key question improved to requires improvement.
- Effective key question remained as requires improvement.
- Caring key question went down to requires improvement.
- Responsive remained as requires improvement.

Well led key question improved to requires improvement.

Urgent and emergency services

Inadequate 

Key facts and figures

Urgent and emergency care services are provided from the Royal Shrewsbury Hospital (RSH) emergency department and the Princess Royal Hospital (PRH) emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a majors unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department.

Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics.

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

From March 2018 to February 2019, there were 121,442 attendances at the trust's urgent and emergency care services.

(Source: Hospital Episode Statistics)

The emergency department (ED) at RSH provides services 24 hours a day, seven days a week. At the time of this inspection, the ED at RSH consisted of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area.
- A triage room.
- A four bedded resuscitation bay. The resuscitation area was used for the treatment of trauma, those requiring treatment for life threatening illness or injury and those who require direct monitoring and immediate life/limb saving interventions.
- 12 majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A Clinical Decisions Unit (CDU) that could accommodate up to 10 patients. The CDU was a short stay inpatient area for ED patients only who require on-going observations, treatments and reviews where the main outcome is discharge from hospital within a 36-hour period.
- Three minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area that could accommodate up to four patients who were well enough to sit and await discharge or further assessment.
- A relatives' room.

Urgent and emergency services

- Two rooms that could be specifically utilised for the assessment and treatment of children.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider.

At the time of our inspection, work was in progress to build a room that could be used by patients who presented with acute mental health concerns.

Urgent and emergency care at RSH was previously inspected by the Care Quality Commission in August 2018. The service was rated as inadequate. A focussed inspection was also completed in April 2019. However, a rating was not awarded to the service due to the focussed nature of the inspection.

We carried out an unannounced inspection of the RSH emergency department from 18 to 20 November 2019 and 26 November 2019. We reviewed 29 patient care records and spoke with 12 patients and four relatives. We also spoke with 47 members of staff including, nurses, doctors, emergency nurse practitioners, therapists, healthcare assistants, receptionists, pharmacists, an associate nurse, a member of security staff, the ward manager, the matron, the head of nursing, the sepsis nurse, the audit manager, the quality improvement lead, the governance lead, and a dementia support worker. We also spoke with three staff who worked alongside the trust within the ED. This included paramedics and a member of staff from the mental health liaison team.

Summary of this service

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

- The service did not have enough permanent staff to care for patients and keep them safe. Staff were not always up to date with mandatory training. This included the training required to ensure staff knew how to protect patients from abuse. Staff did not always assess and manage safety risks well and lessons were not always learned following incidents. Emergency medicines were not always available, and medicines were not always stored securely. Accurate and detailed records were not always maintained or stored securely. Safety performance data was not clearly displayed for patients and staff to view.
- We could not be assured that clinical policies and pathways were based on national guidance and best practice. Managers monitored the effectiveness of the service, but appropriate and timely action was not always taken in response to poor audit findings. Managers did not always complete timely appraisals of staff's work performance and ongoing professional development and support was not consistently available to all staff. Effective systems were not in place to ensure people's dietary requirements were met and staff did not always give patients practical support and advice to lead healthier lives. Staff did not protect the rights of patients' subject to the Mental Health Act 1983 and they did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.
- The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always support people to understand the waiting times for assessment and treatment in the ED.
- The service did not plan care to consistently meet the needs of local people and the individual needs of patients. People could not always access the service when they needed it and they frequently had lengthy waits for treatment. Complaints were not always managed in accordance with trust policy.

Urgent and emergency services

- The service was not well-led. The required improvements from previous inspection had not been made. We identified ongoing and new Regulatory breaches. There was no ED specific vision or strategy and staff did not always feel respected, supported and valued. Information and governance systems were not effective. The service did not engage well with patients and the community to plan and manage services and the services approach to driving improvement was reactive rather than proactive.

However:

- The service mostly controlled infection risk well and managed clinical waste safely. Staffing gaps were filled with temporary staff. The majority of medicines were prescribed, administered and recorded appropriately and when things went wrong, staff apologised to patients and their relatives.
- Staff worked well as a team to benefit patients and some competency checks were in place to confirm that staff had the skills they needed to provide effective care. Staff sought verbal consent from patient's who could make decisions about their care and they gave pain relief when needed. Most ED services were available seven days a week.
- Individual staff members treated patients with compassion and kindness and provided emotional support to patients, families and carers.
- Managers and staff worked with others in the wider system and local organisations to plan care. Reasonable adjustments were made to help patients access the service.

Is the service safe?

Inadequate

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

- The service provided mandatory training in key skills. However, not all staff were up to date with this training.
- Staff were not always up to date with the safeguarding training that would enable them to consistently recognise and report abuse.
- Staff did not always keep equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment did not kept people safe.
- Staff did not always promptly identify and quickly act upon patients at risk of deterioration.
- Staff did not always complete risk assessments for each patient in a prompt manner.
- Staff did not always act to remove or minimise risks or update the assessments when risks changed.
- The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment.
- Detailed records of patients' care and treatment were not maintained within the ED. Records were not always clear, up-to-date or stored securely.
- The service did not have effective systems in place to ensure all medicines were stored securely and in line with manufacturers guidance.
- Emergency medicines were not always available.
- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses.

Urgent and emergency services

- Systems were in place to support managers to investigate incidents and share lessons learned with the whole team and the wider service. However, incidents were not always effectively investigated in a timely manner to reduce the risk of potential harm from similar or repeated incidents.
- The service collected patient safety data. However, this information was not always up to date or clearly displayed for patients and staff to view.

However:

- The service mostly controlled infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection.
- Staff managed clinical waste well.
- Staffing gaps were filled with temporary bank and agency staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Systems were in place to ensure that the majority of medicines were prescribed, administered and recorded appropriately.
- When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Inadequate 

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

- We could not be assured that clinical policies and pathways were based on national guidance and best practice.
- Managers completed some checks to make sure staff followed guidance. However appropriate and timely action was not always taken in response to poor findings.
- Staff did not protect the rights of patients' subject to the Mental Health Act 1983.
- We could not be assured that staff gave patients enough food and drink to meet their needs and improve their health as care records did not always evidence this.
- Effective systems were not in place to ensure that dietary adjustments could be made for patients' religious, cultural and medical needs. No formal nutritional assessments were in place to enable staff to assess and meet patient's individual dietary needs.
- Appropriate action was not always taken in response to poor findings from clinical audits, to make the required improvements and achieve consistent good outcomes for patients.
- Managers did not always complete timely appraisals of staff's work performance.
- Ongoing professional development and support was not consistently available to all staff.
- Staff did not always give patients practical support and advice to lead healthier lives.
- Staff did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.

However:

- Staff monitored the effectiveness of care and treatment.

Urgent and emergency services

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Some systems were in place to check that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide patient care.
- Most emergency department services were available seven days a week to support timely patient care.
- Staff sought the verbal consent of patients who were able to make decisions about their care and treatment.

Is the service caring?

Requires improvement 

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

- The service was not designed or delivered in a manner that respected patients' privacy and dignity.
- Staff did not always have the time to interact with people in a meaningful way.
- Staff did not always support people to understand the waiting times for assessment and treatment in the emergency department (ED).
- Patients were not consistently supported to feedback their experiences of care in the ED through the completion of the Patient Friends and Family Test.

However:

- Individual staff members treated patients with compassion and kindness.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff understood patients' personal, cultural and religious needs.
- When staff communicated with patients and their relatives, they did this in a manner that reflected peoples individual communication needs.

Is the service responsive?

Inadequate 

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

- The service was not designed to provide care in a way that consistently met the needs of local people and the communities served.
- The service and staff did not always meet the individual needs of patients, such as the specific needs of patients living with dementia.
- People could not always access the service when they needed to and they did not always receive the right care promptly.

Urgent and emergency services

- Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.
- Complaints were not always managed in accordance with trust policy.

However:

- Managers and staff worked with others in the wider system and local organisations to plan care.
- Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers when required.
- Systems were in place to enable people to give feedback and raise concerns about care received.

Is the service well-led?

Inadequate 

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

- Leaders did not have the skills and abilities to run the service in a safe and effective manner.
- Leaders did not understand and manage the priorities and issues the service faced.
- Senior leaders were not always visible and approachable in the service for patients and staff.
- The emergency department (ED) service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action.
- Staff did not always feel respected, supported and valued. Some staff reported a bullying culture within the ED and the wider trust and not all staff felt able to report incidents of alleged bullying.
- Leaders in the ED did not operate effective governance processes throughout the service and with partner organisations.
- Work pressures sometimes impacted on the staffs' capacity to regularly meet to, discuss and learn from the performance of the service.
- The service did not always identify, escalate and mitigate relevant risks and issues.
- The information systems were not integrated which meant staff could not always access patient data when they needed it.
- Some performance data was not shared accurately with other organisations.
- Leaders did not always actively and openly engage with staff and patient groups to plan and manage services.
- Increased patient demand in the ED prevented staff from continually learning and improving services.
- Staff told us leaders did not actively encourage innovation or participation in research.

However:

- Changes had been made that supported nursing staff to take on more senior roles within the ED.
- Staff at all levels were clear about their roles and accountabilities.
- The service collected some pertinent data and analysed it.

- Senior leaders engaged with stakeholders regarding the planning of future ED services.

Areas for improvement

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.
- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.
- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.
- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.
- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.
- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.
- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.
- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.
- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.
- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.
- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.
- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.
- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

The service SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.
- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.
- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.
- The service should continue to work with commissioners to improve ambulance handover times.
- The service should continue to embed local initiatives aimed to improve sepsis care.
- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.
- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.
- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.
- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.
- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.

- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.
- The service should explore how to effectively display patient safety information within the ED.
- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).
- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.
- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.
- The service should continue with the implementation of a suitable competency tool for staff working in the ED.
- The service should explore how to improve the training and development opportunities for middle grade medical staff.
- The service should continue to explore how allied health professions could provide a consistent seven-day service within the ED.
- The service should explore how they can make every contact count by offering health promotion advice and support to patients with risks that may affect their long term health and wellbeing.
- The service should consider how to evidence that consent has been sought and gained from patients within the ED.
- The service should consider how they can give accurate and up to date waiting time information to patients and their relatives within the ED.
- The service should explore how to improve patient participation in the Patient Friends and Family Test.
- The service should explore how they can make the ED more user friendly for all patients. This should include a review of the signage within the ED.
- The service should explore how the individual needs of people living with dementia could be met within the ED.
- The service should review the systems in place to improve the availability of information leaflets. This should include reviewing if there is a need to have information leaflets readily available in other appropriate languages and formats within the ED.
- The service should accurately report the numbers of patients leaving before being treated.
- The service should consider introducing a system to effectively monitor the time taken from referral to assessment in regard to the use of the mental health liaison team in the ED.
- The senior leadership team in the ED should explore how to improve their visibility and accessibility to staff and patients.
- The service should explore how the role of the band seven nurse within the ED can be improved to provide a consistent approach to the day to day coronation of the ED.
- The service should consider designing an ED specific vision and strategy outlining short and long term goals whilst the future fit project is in progress.

Urgent and emergency services

- The service should review the 2018 staff survey results and devise an appropriate action plan to address the alleged bullying culture within the ED and wider trust.
- The service should consider how they can evidence that the trust's major incident plan is well rehearsed by staff.
- The service should review the processes in place to enable them to send accurate information with other organisations as required.

Medical care (including older people's care)

Inadequate 

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 areas providing medical care in the service including: haematology and oncology, short stay unit, endocrinology, nephrology, general medicine, respiratory, the acute medical unit, the discharge lounge, coronary care unit, the renal unit, the frailty unit, acute medical unit and endoscopy. On our inspection we spoke with 33 members of staff including registered nurses, doctors, allied health professionals, pharmacists, healthcare assistants and the services leadership team. We spoke with nine patients and three relatives.

The care quality commission last inspected the service in September 2018 and rated the service as requires improvement overall. Safe, effective, responsive and well led were rated as requires improvement and caring was rated as good.

Summary of this service

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

- Staff completion data for mandatory training did not meet the trust targets.
- Infection prevention and control practices were not consistently adhered to within the hospital. Staff did not always wear appropriate personal protective equipment (PPE) and did not always wash their hands between patients.
- Staff completed venous thromboembolism risk assessments for each patient on admission but did not always review this regularly. We were not assured that risks to patients had been managed appropriately.
- Staff did not always follow systems and processes when safely prescribing medicines. We could not be assured that patients received the accurate drug dosing due to the weight not being recorded on medicine charts and the trust's electronic recording system.
- We were not assured staff used measures that limited patients' liberty appropriately and always knew how to support patients who lacked capacity, or who were experiencing mental ill health.
- Facilities and premises were not always appropriate for the services being delivered. The lack of appropriate facilities within the renal unit meant privacy and dignity could not always be maintained.
- We were not assured that the staff moved to other ward areas including escalation areas had necessary competencies to enable them practice safely.
- Governance systems were in place to monitor and assess risk but did not ensure risks such as compliance with mandatory training and infection prevention and control which had been identified during our inspection in September 2018 had been rectified.

Medical care (including older people's care)

Is the service safe?

Requires improvement ➔➔

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

- The service provided mandatory training in key skills to staff, compliance was monitored but consistently did not meet the trust target.
- The service did not always control infection risk well. We could not be fully assured that infection prevention and control (IPC) practices were consistently adhered to. However, staff kept the premises visibly clean.
- Whilst staff assessed risks to patients and monitored their safety, they were not always completed for every patient when required. However, staff identified and acted upon patients at risk of deterioration.
- We were not assured that risk assessments were carried out for patients living with mental health conditions and attending the renal unit.
- The service did not always use systems and processes to safely prescribe medicines. However, they administered, recorded and stored medicines safely.
- The service did not have enough permanent medical, nursing, therapy and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. This had improved since our last inspection.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement ➔➔

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

Medical care (including older people's care)

- Staff did not always know how to support patients who lacked capacity, or who were experiencing mental ill health to make their own decisions and did not always use measures that limited patients' liberty appropriately. However, staff supported patients to make informed decisions about their care and treatment.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. However, staff protected the rights of patients' subject to the Mental Health Act 1983.
- Some key services were available seven days a week to support timely patient care. However, patients were not routinely reviewed by doctors at weekends.

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 adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff mostly monitored the effectiveness of care and treatment. They used the findings to make improvements and mostly achieved good outcomes for patients.
- The service made sure most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 

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

- Staff did not always take patients individual needs into account and did not ensure patients' privacy and dignity was always maintained. However, they treated patients with compassion and kindness.

However:

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

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

Medical care (including older people's care)

- The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, facilities and premises were not always appropriate for the services being delivered.
- Staff did not respond to complaints in a timely manner.
- Staff moved patients between wards at night and did not justify if the bed moves were for clinical or non-clinical reasons.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Governance processes in some areas were not embedded to ensure consistency across the service.
- The service did not have effective systems for planning to eliminate or reduce risks and coping with both the expected and unexpected.
- Most managers had the right skills and abilities to run the service providing high-quality sustainable care. However, new changes required after a death on the renal unit had not always been implemented.

However:

- The service 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 service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, staff morale was sometimes low due to being moved to provide cover during staff shortages.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems.
- The service engaged well with patients and their relatives to plan and manage appropriate services.
- The service was committed to improving services by learning from when things went well and when they went wrong and promoting innovation.

Medical care (including older people's care)

Areas for improvement

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.
- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.
- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.
- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.
- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.
- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

The service SHOULD take action to:

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.
- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

Surgery

Requires improvement 

Key facts and figures

The surgery core service provides care and treatment for specialties including breast surgery, colorectal surgery, ear nose and throat (ENT), head and neck, ophthalmology, upper gastro-intestinal surgery, urology and vascular surgery.

(Source: Routine Provider Information Request AC1 - Acute context)

Surgical services are provided on both the Royal Shrewsbury Hospital (RSH) and The Princess Royal Hospital (PRH) sites.

RSH surgical admissions unit accepts all surgical emergency patients referred by GPs and admitted from the emergency departments at both RSH and PRH sites. RSH is a designated trauma unit.

The surgery core service at this hospital provides care and treatment for specialties including colorectal surgery, upper gastro-intestinal surgery, urology and vascular surgery. In addition, ears, nose and throat (ENT) and ophthalmology day case surgery is carried out at this site.

Royal Shrewsbury Hospital has nine operating theatres and 119 surgical inpatient beds located across four wards and units.

RSH, Shrewsbury and PRH, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the same scheduled care group across the hospitals and had the same clinical directors.

This evidence appendix relates to surgery services provided at RSH, Shrewsbury, which provided both elective and emergency surgery.

Surgical services at RSH was previously inspected by the Care Quality Commission in August. The service was rated as requires improvement, although caring was rated as good.

During our unannounced inspection from 18 to 20 November 2019 and 02 December 2019, we visited all areas providing surgery services at the hospital, including the surgical assessment unit and short stay ward, pre-assessment, the day case unit and short stay ward, and two surgical wards, theatres and recovery. We spoke with 11 patients and observed patient care and treatment. We reviewed 18 patient care records and 10 medicine administration records. We spoke with 42 members of staff including nurses, doctors, anaesthetists, surgeons, therapists, healthcare assistants, housekeeping staff, theatre practitioners, ward managers, matrons, pharmacists and dementia care assistants. We also interviewed some members of the senior management team within the scheduled care group.

Summary of this service

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

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed mandatory training did not meet trust targets.
- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with children and young people under 18 in theatres, did not have the correct level of safeguarding training.

Surgery

- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.
- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.
- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were not always clear and up-to-date and were not always stored securely.

However:

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.
- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service safe?

Requires improvement 

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

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.
- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with young people under 18 in theatres, did not have the correct level of safeguarding training.

Surgery

- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.
- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.
- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.
- Records were not always clear and up-to-date and were not always stored securely.

However:

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.
- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement 

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

- The service achieved mixed outcomes for patients. Plans were in place to improve this.
- Managers did not hold supervision meetings with staff to provide support and development.
- Appraisal rates did not meet trust targets.
- Multidisciplinary meetings were not consistently held across all specialities.

Surgery

- There was very low staff compliance with mandatory training in Mental Capacity or Deprivation of Liberty Safeguards.

However:

- Staff monitored the effectiveness of care and treatment.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Most staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
-

Is the service caring?

Requires improvement 

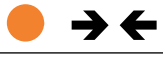
Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always demonstrate they respected the privacy and dignity of patients who stayed overnight in the surgical assessment unit. Poor care had become normalised.
- Staff did not always demonstrate empathy in delivering bad news to patients in a private space.

However:

- Staff treated patients with compassion and kindness and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make 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:

Surgery

- Capacity did not meet the demand of the service and patients were boarded on the surgical assessment unit to accommodate them.
- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Complaints were not always responded to in a timely manner and the service took longer to investigate than the trust average. The average days it took to investigate was more than our previous inspection in 2018.

However:

- We saw the service planned and, in most cases, provided services in a way that met the needs of local people.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- Managers were not always available out of hours and leaders were not always visible and approachable in the service for patients and staff.
- The strategic priorities of the service did not demonstrate they were aligned to local plans within the wider health economy.
- Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.
- We were not assured the service identified all risks. Risks had been on the risk register for long periods and did not always demonstrate they were being effectively managed to reduce their impact. Not all risks we identified during our inspection were on the service risk register.
- The service collected reliable data and analysed it, however, systems did not provide managers with information to assess volume and waiting times of patients attending the surgical assessment unit.
- The service had not made significant improvements within surgical services at the Royal Shrewsbury Hospital following our previous inspection in 2018.

However:

- Most leaders had the skills, knowledge and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

Surgery

- Staff felt increasingly respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.
- Leaders and teams used systems to manage performance. Systems were in place to identify and escalate risks and issues.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff engagement with patients, staff, the public and local organisations to plan and manage services was improving. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Most staff had a good understanding of quality improvement methods and the skills to use them.

Outstanding practice

We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.

Surgery

- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.
- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.
- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.
- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.
- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

The service SHOULD take action to

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.
- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.
- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.
- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.
- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.
- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.
- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.
- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.
- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.
- The service should consider reviewing management staffing out of hours to support the provision of seven day working.
- The service should review the process for providing agency staff with immediate access to electronic records and systems.

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 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, four ward managers, four ward sisters, one staff nurse, one nurse associate, one healthcare assistant, the head of pathology, the mortuary manager, the bereavement manager, three administrators, three porters, one end of life care volunteer, five patients and three family members. We also reviewed ten care records.

Summary of this service

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

- The service did not have enough staff to care for patients and keep them safe. Staff did not always keep good care records.
- Key services were not available seven days a week. Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not audit fast track discharges and achievement of preferred place of care and death.
- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

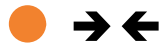
However:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information.

End of life care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

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

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.
- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff used infection control measures when visiting patients on wards and transporting patients after death.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- Records were stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

End of life care

Is the service effective?

Requires improvement 

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

- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- 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 needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Good

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

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

End of life care

- The service did not audit fast track discharges and waiting times from referral to achievement of preferred place of care and death.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.
- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.
- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

Areas for improvement

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

End of life care

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

The service SHOULD take action to:

- The service should carry out plans to employ more than one whole time equivalent (WTE) chaplain.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Requires improvement

Key facts and figures

Outpatient services at Shrewsbury and Telford Hospital NHS Trust are provided across two hospital sites, The Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital.

The central outpatient function is managed by the Scheduled Care Group with the exception of the fracture clinic which is managed by the Unscheduled Care Group.

While some outpatient facilities for children are provided alongside those for adults, children's outpatients provision is not included in this section of the report. Similarly, outpatient provision for maternity services is excluded.

At the Royal Shrewsbury Hospital there is a central outpatients facility that covers cardiology, urology, breast, gastroenterology as well as general surgical and medical specialties.

There are separate departments for:

- Ophthalmology (Eye Clinic).
- Surgical Pre Assessment.
- Fracture Clinic.
- Endocrinology.
- Renal.
- Phlebotomy (blood samples).

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the trusts' activity through the main outpatient department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury Hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings.

During our inspection we:

- visited the main outpatient department, phlebotomy, surgical pre assessment, the eye clinic, the fracture clinic, the endocrinology clinic and the renal clinic.
- spoke with 4 relatives and 12 patients.
- spoke with 28 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and managers.
- looked at 8 sets of patient records.
- observed interactions between patients, relatives and staff.
- observed two patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and usually managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Most people could access the service when they needed it and did not wait too long for treatment. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There were not enough clinic rooms in some areas and this resulted in patients not being seen.
- In one area assessment rooms were too cramped or poorly lit for safety
- Staff did not have the training they needed to support patients who lacked capacity to make their own decisions.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.
- Information system were not integrated with one another relying on duplication of data entry and many systems were paper based.

Is the service safe?

Requires improvement

We rated it as requires improvement because:

- There were shortfalls in training for fire safety and infection prevention and control.

Outpatients

- There were concerns in the eye clinic about the suitability of the lighting and the equipment fit in some rooms. There was also an insufficient number of clinic rooms available in some areas to accommodate the demand.
- Equipment, while cleaned between patients, was not always labelled as such.

However:

- The service provided mandatory training in key skills to all staff and made sure most staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment usually kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and usually available to all staff providing care. While there were continuing problems with the central records store which caused difficult in finding records, the trust had a costed and approved plan to address them. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

We do not currently provide a rating for effective.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Outpatients

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff followed national guidance to gain patients' consent.

However:

- Because of changes to training arrangements the trust could not be assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement

We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- People did not always access the service when they needed it and some patients did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards for some cancer specialities.

Is the service well-led?

Good

Outpatients

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

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and most had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams managed performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected data and analysed it. The information systems were secure.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

However:

- Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not well integrated across the organisation.

Areas for improvement

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.
- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

The service SHOULD take action to:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.
- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.
- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.

Outpatients

- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.
- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems.

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 Diagnostic and screening procedures 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 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures 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

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Maternity and midwifery services	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29A Warning Notice: quality of healthcare
Diagnostic and screening procedures	
Family planning services	
Management of supply of blood and blood derived products	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Treatment of disease, disorder or injury	S31 Urgent variation of a condition

Our inspection team

Bernadette Hanney, Head of Hospitals Inspection, led this inspection. An executive reviewer, Susan Field, Director of Nursing, Gloucestershire Health and Care NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included 17 inspectors and 38 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.