Shrewsbury and Telford Hospital NHS Trust

The Princess Royal Hospital

Inspection report

Grainger Drive
Appley Castle
Telford
TF1 6TF
Tel: 01952641222
www.sath.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at The Princess Royal Hospital

Inspected but not rated

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. Together the hospitals have just over 700 beds and assessment & treatment trolleys.

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, upper GI, urology and vascular surgery.

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.

We carried out this unannounced focused inspection because we had received information giving us concern about the safety and quality of the provision of anaesthetic cover at The Princess Royal Hospital out of hours.

At this inspection we inspected using our critical care inspection framework. We focused only on the provision of anaesthetic cover out of hours as this was where the concerns lay. Critical care at The Princess Royal Hospital was last inspected in 2018 and was rated as requires improvement. Please refer to our previous trust and location reports for details of regulatory action taken.

We did not inspect any other services at the trust during this inspection because inspection activity during Covid 19 is completed using a risk-based approach. We continue to the monitor the trust closely to identify new and emerging risks and track the trust's progress against their improvement plan.

Using the critical care framework, we inspected elements of the key lines of enquiry of safe, effective, responsive and well-led. Due to the focused nature of this inspection, we did not rate key questions.

During our inspection we visited a variety of wards and services from both within and outside of the critical care framework. This was to ensure we spoke to staff throughout the hospital about anaesthetic cover. Wards and services visited included; critical care, critical care outreach team, the maternity delivery suite, the children's ward, the emergency department, the head and neck surgical ward, the acute stroke unit, a general medical ward and a respiratory ward.

We spoke with eleven nursing/midwifery staff, five doctors, two anaesthetists, one operating department practitioner, two matrons and representatives from the senior leadership team.

We reviewed incident data, theatre registers, staff rotas and governance records; such as minutes of governance meetings and relevant policies and procedures.

Our findings

Following our inspection, we also gave the anaesthetic staff the opportunity to participate in a virtual focus group as they were not all able to talk to us whilst we were on site.

Our rating of this location stayed the same.

Summary of findings:

- Effective handover systems were in place locally to ensure appropriately qualified staff had access to the information they would need to respond to deteriorating patient's in the critical care unit. Anaesthetic staff quickly acted upon patients at risk of deterioration. However, there was a risk of delays in responding to deteriorating patients as capacity and demand for critical care beds increased.
- The service made sure staff were competent for their roles. Managers held 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.
- 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.
- People could access the service when they needed it and received the right care promptly.
- Leaders operated effective governance processes. 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 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.

However,

- The service did not have enough anaesthetists with the right intensive care qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The risks posed by this were mitigated with the use of general anaesthetic staff out of hours.
- Staff did not always recognise and report incidents relating to anaesthetic staffing. This meant managers could not effectively identify and take action to respond to anaesthetic staffing risks.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, the senior leadership team were not always visible and approachable in the service for patients and staff.
- Some medical staff at the Princess Royal Hospital did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. Some medical staff did not always feel that the service had an open culture where staff could raise concerns without fear.

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Inspected but not rated

Our rating of this service stayed the same. We inspected safe, effective and well led in response to whistle blowing concerns that were raised with us. We did not inspect caring or responsive as part of this inspection.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Effective handover systems were in place locally to ensure appropriately qualified staff had access to the information they would need to respond to deteriorating patient's in the critical care unit. Anaesthetic staff quickly acted upon patients at risk of deterioration. However, there was a risk of delays in responding to deteriorating patients as capacity and demand for critical care beds increased.

All patients within the intensive care unit (ITU) should be reviewed by a consultant in intensive care medicine (commonly known as an Intensivist). A consultant in intensive care medicine is defined as a consultant who is a Fellow or Associate Fellow or eligible to become a Fellow or Associate Fellow of the Faculty of Intensive Care Medicine. At the 6pm when the on-site the consultant intensivist in ITU handed over patients on the Princess Royal Hospital to the anaesthetic registrar prior to leaving shift. However, there was no handover of patients within this unit to the intensivist on call at The Royal Shrewsbury Hospital. We were told that this was due to over burdening the intensivists at The Royal Shrewsbury Hospital site and an escalation plan being in place. The trust does not have electronic records so any handover or discussion regarding patients was undertaken verbally and relied on the information that the anaesthetist was able to supply to the intensivist at The Royal Shrewsbury Hospital.

All but one of the 15 nurses, midwives, doctors and operating department practitioners we spoke with told us that anaesthetic staff responded promptly out of hours when deteriorating patients were escalated to them. This included prompt responses to patient's requiring respiratory support, cardiac arrest calls and requests for anaesthesia for emergency surgery. Only one staff member from this staffing group reported occasional delay's in the out of hours responses from the anaesthetic staff. However, they were unable to share examples of these delays and no delays had been reported by staff through the trust's incidents reporting database.

Anaesthetic staff told us that although they responded promptly to deteriorating patients, this was at times very challenging due to the number of services they were required to provide cover to out of hours. These services included; the critical care unit, the emergency department, all medical and surgical wards for children and adults and very occasionally additional cover to maternity services was also required.

The critical care outreach team (CCOT) are called to assess any acutely ill or deteriorating ward in-patient who is causing concern (excludes Obstetrics, Neonatal Critical Care Unit and Paediatrics) between the hours of 7:30am and 8pm.

Between 1 October 2020 and 31 December 2020 31 CCOT shifts were uncovered due to staff absence and two shifts were uncovered due to CCOT staff being pulled to work on the critical care unit. Staff told us that when CCOT shifts were

uncovered, this was escalated to senior managers and the CCOT bleep was held by the critical care unit staff who would respond to the bleep if they were able to do so. This meant that at times, out of hours, there would be increased pressures on other staff groups such as medical staff and critical care staff already assigned to direct patient care on the unit to respond to deteriorating patients when the CCOT shifts were unfilled.

Medical staffing

The service did not have enough anaesthetists with the right intensive care qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the risks posed by this were mitigated with the use of general anaesthetic staff out of hours.

The critical care service had anaesthetic staff vacancies. At the time of inspection, there were two Consultant Anaesthetist vacancies for consultants with a special interest in ENT and Obstetrics and five vacancies for the critical care service.

The critical care service always had a consultant on call during evenings and weekends. The consultant anaesthetist body use an electronic system that was populated by the anaesthetic secretary under the direction of a consultant anaesthetist to manage rotas within the critical care department. This system can produce management reports and highlights any gaps within the rota. Any gaps in the rota were normally filled by the use of locums, or in some cases consultants and others acting down into junior roles.

Anaesthetic out of hours rotas we viewed show for the time periods of 1 November 2020, 30 November 2020, 18 December 2020 and 8 January 2021 that the rota was consistently covered.

When we inspected the critical care service last in 2018 there was provision of an intensivist within the critical care unit (CCU) five days a week from 8am to 6pm. At this inspection we found that cross site working had been implemented to support those intensivists working predominantly at the Princess Royal Hospital site. Cover was now provided to the critical care unit by intensivists seven days a week between 8am and 6pm on site and outside of these times through an on-call intensivist at The Royal Shrewsbury Hospital site. On site out of hours provision for deteriorating patients from across the hospital was provided by two on site general anaesthetists, and a third anaesthetist (middle grade) for obstetrics, supported by an on-call consultant anaesthetist. The registrar was predominantly based on the critical care unit but supported the junior anaesthetist on call. The on-call team felt well-supported by the general anaesthetic consultants in that they were not expected to manage patients outside their clinical competence but did often feel stressed with multiple patients to manage in different areas.

Incidents

Staff did not always recognise and report incidents relating to anaesthetic staffing. This meant managers could not effectively identify and take action to respond to anaesthetic staffing risks.

Staff knew how to report incidents. However, incidents were not always reported in line with the trust's incidents policy. In addition to the one nurse who told there were occasional delays in anaesthetic response time out of hours, anaesthetists also referred to occasions where risks to patient safety were posed due to the demands placed onto their roles out of hours. We asked the trust for data relating to these near misses or potential incidents. However, only one

incident relating to this had been reported within the six months leading up to our inspection. This incident resulted in a minor delay to starting a theatre surgery list as the anaesthetist was unable to start a day shift on time as they had been called out to the hospital out of hours. The incident resulted in no harm to patients and the planned surgeries took place.

Staff told us they no longer reported all incidents and near misses due to time constraints and a general apathy from past experiences where they felt action not always being taken in response to incidents that had been reported in the past.

Not reporting all near misses and incidents meant managers did not have effective oversight into all the near misses and potential incidents relating to the provision of out of hours anaesthetic cover.

Is the service effective?

Inspected but not rated

Competent staff

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

The anaesthetists who provided out of hours cover for the ITU were qualified to deal with emergency situations but were not a consultant in intensive care medicine as defined by the Faculty of Intensive Care Medicine guidance. The leadership team felt that the general anaesthetic consultants had appropriate transferrable skills to optimise a patient in the first 12 hours of their admission and provide care for most ICU patients already admitted to the unit overnight. The general anaesthetic consultants had been providing this cover for many years, however some felt that they did not have the up-to-date skills and knowledge to care for some of these patients- particularly the complex medical patients.

As part of governance meetings, ICU training was available for all anaesthetists. However, we were sent records from October and November 2019 which demonstrates that training was given to those present. However, these were held at The Royal Shrewsbury Hospital site and did not demonstrate that consultant anaesthetists from the Princess Royal Hospital site were present. There was no evidence of a structured training plan for individuals (according to the GMC identifying specific areas for development is the responsibility of an individual). A website also provided training videos and links to other resources for all doctors. The clinical director had also introduced “learning from excellence” to promote good care. Training for anaesthetic staff had been provided during the first wave of the Covid pandemic, this included coronavirus specific training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. In critical care these had been extended to include the tracheostomy practitioner, rehabilitation specialists, pharmacy and physiotherapy expertise.

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Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. At the Princess Royal Hospital services for patients who required extra support such as critical care were provided. Due to the nature of services provided at the Princess Royal Hospital the trust was committed to provide critical care services at both sites despite not having sufficient intensivists to provide onsite cover over the 24hr period. Critical care services worked with the Intensive care network both regionally and nationally to maintain and improve services for patients.

There was a plan for managing surge capacity in the third wave of the coronavirus pandemic. This had been considered with the current provision available within the trust. This plan included expansion of the CCU services at The Royal Shrewsbury Hospital into recovery and this being used at as the primary expansion site, due to the provision of intensivists at this site, and further expansion of the CCU at the Princess Royal Hospital into either Theatre 5 or the recovery area. There had been careful consideration of manging surge capacity, decompression of the Princess Royal Hospital site and mindful that the out of hours provision cover was not optimal.

There were plans, which had been on hold for a number of years, around the relocation of services and the development of an emergency centre which would see designated services at each location. Whilst some relocation of services had been undertaken, such as maternity and paediatric services as well as some surgery services, this was still a plan in progress and a new build awaiting agreement. This impacted upon the provision of critical care services across the trust. Service leaders had put in place interim solutions which mitigated the risks of harm to patients.

The service had systems to help care for patients in need of additional support or specialist intervention. The critical care unit (CCU) was beginning to function as a cross county service. The Princess Royal Hospital CCU was supported out of hours by the intensivist at The Royal Shrewsbury Hospital CCU to provide advice and support.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers in the critical care service monitored access and review by a consultant intensivist within 12 hours of admission. The services used both data submitted to the Intensive Care National Audit and Research Centre and compliance with the guidelines for the provision of intensive care services produced by The Faculty of Intensive Care Medicine. This guidance stated that all patients should have a review by an intensivist within 12 hours of admission. However, at the Princess Royal hospital site this would not necessarily occur due to the on-call arrangements in place. The trust sent us an audit following our inspection which demonstrated that whilst the average time to review between November 2018 and January 2019 was 4.5 hours there were 18 patients who exceed the target time. These patients

waited between 12 hrs 10 minutes and 15 hours for review. It was not clear from the data provided which site these patients were at although all patients had been admitted after 5pm. Due to the lack of incident reporting it concluded that potential harm had been avoided. However, it recommended improved reporting of delays. At our inspection we could not find any reports of delays to patients being assessed by an intensivist.

Is the service well-led?

Inspected but not rated

adership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, the senior leadership team were not always visible and approachable in the service for patients and staff.

The local leaders of the service and the clinical director were visible and approachable. They understood the challenges that the service faced. The care group team, who managed the service across the trust, were less visible at the Princess Royal Hospital and staff felt that not all members of the team appreciated the challenges they faced within the service

All leaders were aware of the challenge of providing on site intensivist support to the critical care unit at Princess Royal Hospital. They were aware that this had been a long-standing issue which had improved since our last inspection of this service in 2018 with seven-day cover during the hours of 8am – 6pm. However, the ability to recruit intensivist and the delayed plans for the emergency centre impacted upon the trusts ability to provide 24hour intensivist cover across the ITU service.

Culture

Some medical staff at the Princess Royal Hospital did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. Some medical staff did not always feel that the service had an open culture where staff could raise concerns without fear.

Some anaesthetic staff did not always feel respected, supported or valued by senior staff. The issue around the provision of the out of hours service was well known and had been raised a number of times since the merger of the two sites but had not been fully or appropriately addressed. There was a culture where the staff at the Princess Royal Hospital felt that they were a second class ITU and were not afforded the same degree of respect that the medical staff at The Royal Shrewsbury Hospital were. This was evidenced through the language used by some staff who referred to the Princess Royal Hospital unit as being less complex, being less busy and being a small district general hospital. Some anaesthetic staff felt that there was a lack of appreciation of the specific needs of the ITU at the Princess Royal Hospital ITU. This included that decisions were made across sites without consideration of the issues at the Princess Royal Hospital.

Some anaesthetic staff did not understand the rationale for not having an intensivist at the Princess Royal Hospital and felt that the complexity of the patients at this hospital was not always recognised alongside the provision of out of hours cover at this site by the leaders of the service. The leaders of the care group and the intensivists based at the Princess

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Royal Hospital a could state that the dependency at The Royal Shrewsbury Hospital ITU was 8 and at Princess Royal Hospital this was 6. However, they were aware that the out of hours provision had been an ongoing concern and issue for a significant period of time. The clinical director was focused on cross county working and all new appointments were to cover both sites.

Some anaesthetic staff felt that there was a culture where they could not raise issues without fear. They cited examples where they had felt belittled and undervalued through the actions and behaviours of senior staff. They said that this included the problem being pushed back to them to resolve without support or eye rolling behaviour. However, staff who worked cross-county felt more able to raise concerns with the care group as they saw them at The Royal Shrewsbury Hospital when working at that site.

Governance

Leaders operated effective governance processes. 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.

The clinical director had improved the governance processes and strengthened this through encouragement of cross directorate working. There is one intensivist who works solely at the Princess Royal Hospital there were some who worked across sites. We were told that the governance meetings had been expanded to include all medical staff caring for ITU patients as well as the tracheostomy practitioner, rehabilitation specialists, pharmacy support and physiotherapist support. This ensured that all staff were sighted on issues and received training on various scenarios. We were also sent minutes of the Critical Care Clinical Operational group which demonstrated that each site reported into this committee the risks and oversight. This meeting also considered policies, lessons learnt and a brief update on the morbidity and mortality meetings. However, the staff present at this meeting were limited to managers and leads from the services. We were not sent any evidence that other staff attended these meetings.

Following our inspection in 2018 the trust had implemented an action plan to address the issues we highlighted. There was greater emphasis on working across the county and whilst the Princess Royal Hospital had intensivists who were dedicated to working at this site those based at The Royal Shrewsbury Hospital ITU provided cover and support alongside two regular locum intensivists. There were plans to encourage other disciplines to become a cross county resource. All new appointments to medical posts were designed to be cross county posts. The trust had also standardised ways of working within the critical care service. This was an improvement since our previous inspection.

Management of risks, issues and performance

Leaders and teams used systems to manage 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 general anaesthetic staff had raised concerns regarding the provision of support from an intensivist out of hours for many years. However, despite a Deanary visit in 2016 and subsequent action plan they felt that little had changed. Whilst a new system of support had been implemented to provide on-call support from the intensivist during out of hours this was not formalised in a policy or standard operating process, and not always accessed by the staff working at the Princess Royal Hospital. Staff told us that support was accessed via a consultant to consultant discussion. This meant that in practice the registrar level general anaesthetist had to discuss patient with their general anaesthetic consultant prior to the consultant having a discussion with the consultant intensivist. There were a number of factors

which impacted up on this discussion. These included the lack of telemetry, a lack of handover regarding patients currently on the critical care unit and poor working relationships between the specialities. Some anaesthetists at the Princess Royal Hospital felt that their contribution to patient care was not respected or valued by staff at The Royal Shrewsbury Hospital.

The care group leaders outlined the history of the issues. The trust had received some monies to split the anaesthetic and intensivist rotas. It had been feasible to do this earlier at the Royal Shrewsbury Hospital site due to the number of intensivists there. This has been more difficult to do at the Princess Royal Hospital site due to the number of intensivists in post but there is the budget, with the funding for five posts too recruit to enable this to then happen They recognised that this was inequitable but felt that it was important for one site to be moving forward. They had also submitted business cases for an increase in therapy services for the units but recognised that without being able to recruit further intensivists it would be difficult to provide an equitable service across both sites.

There was no evidence of impact of the current provision of service at the Princess Royal Hospital. This was due to a lack of incident reporting around the on call provision including, the number of times the intensivist had been called about a patient or attended site, delays in time to review patients on wards, the workload of the on call general anaesthetic consultant and junior anaesthetic staff whilst on call. The care group leadership team monitored all incidents reports and mortality within the service as indicators of how well the service was performing.

During the first wave of the pandemic the staff at Princess Royal Hospital were supported to manage surge capacity with cover at all times by an intensivist on site. However, this was not sustainable in the longer term, so the trust had reverted to previous plans for cover from the intensivists. Discussions were currently occurring as to the provision of cover during this third wave. This included the provision of an intensivist on site between the hours of 8am – 8pm or 10pm. However, whilst the primary surge capacity was at The Royal Shrewsbury Hospital, there were plans for the Princess Royal Hospital to expand capacity within the theatre department should this be necessary.

The trust monitored performance and adherence to national standards through participating in the Intensive Care National Audit and Research Centre (ICNARC) reporting, auditing of key areas and monitoring through a critical care standards tracker. The most recent ICNARC report from 01 April to 30 June 2020 showed patient outcomes continued to be good. This reporting period covered the first wave of the coronavirus pandemic. During this reporting period there had been 51 admissions. The risk adjusted hospital mortality ratio (all patients) was 34%; the risk-adjusted hospital mortality ratio for patients with predicted risk of death lower than 20% was 7.4%. There were no patients discharged out of hours and no nonclinical transfers to other units. All these measures were within or lower than the range expected. There were no unplanned readmissions to the ITU and no unit acquired infections in the blood.

The trust had begun to monitor themselves against the guidelines for the provision of intensive care services produced by the Faculty of Intensive Care Medicine June 2019. This document had standards of care which the trust must meet and recommendations that it should strive to meet. The trust had produced a dashboard spreadsheet in which it measured itself against these standards and recommendations. This spreadsheet demonstrated that the Princess Royal Hospital met some of the standards. The Royal Shrewsbury Hospital which met most standards relating to medical staffing.

Following our previous inspection of the critical care service at the Princess Royal Hospital, the trust had been issued a warning notice in relation to providing sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to provide patients with safe care and treatment. This related specifically to consultant in intensive care medicine and allied health professional provision. The trust had developed an action plan and had

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improved the service provision at the Princess Royal Hospital. Since our inspection in 2018 the cross-county service had ensured that there is a seven-day intensivist on site during 8am – 6pm who undertakes at least twice daily ward rounds. The clinical director had worked with the local authority to refurbish three houses within Telford in order to offer junior doctors free accommodation and to support them whilst working at the Princess Royal Hospital.

Areas for improvement

Managers should consider how they listen to staff working within the critical care unit to ensure that they feel confident to undertake this role.

Managers should continue to explore ways of recruiting to vacancies in critical care.

Managers should consider formalising the referral and support processes currently in place within this service.

Our inspection team

The team that inspected the service comprised a Head of Hospital Inspection, two inspectors and a clinical fellow with a background in anaesthetics.