

# Shrewsbury and Telford Hospital NHS Trust

## Quality Report

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

## Ratings

### Overall rating for this trust

Requires improvement 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Good 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Requires improvement 

Are services at this trust well-led?

Requires improvement 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

We inspected this trust using our comprehensive methodology in October 2014. At that time we rated the trust requires improvement overall, and we had particular concerns about end of life care at Royal Shrewsbury, which was rated inadequate. Since our last inspection, we can see that the trust has made significant improvements in a number of areas, including end of life care. We also noted a positive change in culture amongst staff and leaders. The overall rating reflects the fact that the trust still have some way to go on its improvement journey but the change in ratings in a numbers of areas acknowledges what they have achieved so far.

We rated Shrewsbury and Telford Hospital NHS Trust as requires improvement overall.

- Insufficient numbers of consultants and middle grade doctors were available.
- Nursing staff vacancies were impacting on continuity of care and an acuity tool was not used to assess staffing requirements.
- The trust was not achieving the Department of Health's target to admit, transfer or discharge 95% of patients within four hours of their arrival in ED.
- Ambulance handover times regularly fell below national standards.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015.
- The triage process for patients brought in by ambulance was inconsistent and unstructured.
- Attendance levels for mandatory training were noted to be poor in most areas

- Compliance with the trust target for completion of staff appraisals was below the trust target.
- There were three Never Events relating to retained products following surgery,
- Current safety thermometer information was not displayed on the wards
- The maternity specific safety thermometer was not being used to measure compliance with safe quality care.
- In maternity services, feedback to staff on incidents was described as inconsistent and only a few midwives told us they had received feedback.
- Inconsistencies were identified in the staffs application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist.
- Mortuary staff decontaminated surgical instruments manually; this exposed staff to unnecessary risk and did not provide a high level of disinfection.
- Mental capacity documentation had not been completed for defined ceiling of treatment decisions when a person had been deemed as lacking capacity.

However, we also saw that:

- Openness and transparency about safety was encouraged. Incident reporting was embedded among all staff, and feedback was given. Staff were aware of their role in Duty of Candour.
- In every interaction we saw between nurses, doctors and patients, the patients were treated with dignity and respect. Staff were highly motivated and passionate about the care they delivered.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Treatment was planned and delivered in line with national guidelines and best practice recommendations

# Summary of findings

- Local and national audits of clinical outcomes were undertaken and quality improvements projects were implemented in order
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so.
- There was clear statement of vision and values, driven by quality and safety. Leaders at every level prioritised safe, high quality, compassionate care.
- The trust had made end of life care one of its priorities in 2015/2016.
- The trust must ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery.
- The trust must ensure there are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients
- The trust must review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times.

We saw several areas of outstanding practice including:

- The trust had rolled out the Swan scheme across the trust which included a Swan bereavement suite, Swan rooms, boxes, bags and resource files for staff.
- The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life patient.
- Virginia Mason Institute (VMI) designed and developed its systems to become widely regarded as one of the safest hospitals in the world. The trust embraced these methodologies and in partnership with VMI, they have developed new initiatives within the hospital. They used the model to create the transforming care institute (TCI). TCI wants an effective approach to transforming healthcare by coaching teams and facilitating continuous improvement.

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

- The trust must ensure ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients with four hours of their arrival in the department.
- The trust must ensure all patients brought in by ambulance are promptly assessed and triaged by a registered nurse.
- The trust must ensure a suitably qualified member of staff triages all patients, face to face, on their arrival in ED by ambulance.

- The trust must ensure that all staff are up to date with mandatory training
- The trust must ensure that all staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required.
- The trust must ensure the application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist is improved in theatres
- The trust must ensure that up to date safety thermometer information is displayed on all wards
- The trust must ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning.

In addition the trust should:

- The trust should ensure all staff received an annual appraisal.
- The trust should consider using the maternity specific safety thermometer to measure compliance with safe quality care.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales.

The main registered locations are the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury. Both hospitals provide a wide range of acute hospital services, which provide the majority of activity. Alongside these acute services, the trust provide midwife led maternity care at Ludlow Community Hospital, Bridgnorth Community Hospital and Oswestry Maternity Unit. The trust also provides consultant-led outreach clinics (including the Wrekin Community Clinic at Euston House in Telford) and renal dialysis outreach services at Ludlow Hospital.

The trust has around 835 inpatient beds, across approximately 73 wards and employs over 5700 staff.

The health of people in Shropshire is generally better than the England average whilst the health of people in Telford and Wrekin is varied compared with the England average. Deprivation in Shropshire is lower than the England average, with about 12.7% of children living in poverty (significantly better than England average), whilst 23% (7,800) children in Telford and Wrekin live in low

income families; however rates of statutory homeless are significantly worse than average at 3.4%. Life expectancy for both men and women in Shropshire is significantly higher than the England average. In Telford and Wrekin life expectancy for both men and women is 6.9 years lower in the most deprived areas of Telford and Wrekin compared to the least deprived areas. The rate of smoking related deaths in Telford and Wrekin is worse than the average for England.

The trust has a relatively new executive team. The chief executive took office in 2015 whilst the chair has been in post since 2013. The director of nursing and medical director were also appointed in 2013. The chief operating officer has been at the trust since 2012, and the finance director is the longest standing member of the executive team (since 2011).

The trust has achieved “teaching hospital status” through partnership with the Keele University School of Medicine. It also has links with other medical schools in Birmingham and Manchester.

Shrewsbury and Telford Hospital NHS Trust has been inspected 12 times since its registration with the CQC in April 2010. The trust was last inspected in October 2014 and was rated as “requires improvement”.

## Our inspection team

Our inspection team was led by:

Chair: Nigel Acheson Regional Medical Director (South), NHS England

Team leader: Debbie Widdowson, Inspection Manager, Care Quality Commission

The team of 30 included CQC inspectors and a variety of specialists: medical consultant, A&E consultant, consultant obstetrician, consultant surgeons, senior nurses, modern matrons, specialist nurses, theatre nurses, emergency nurse practitioner and senior midwives.

## How we carried out this inspection

The inspection took place from 12 to 15 December 2016. It was carried out as a focused, short notice inspection, concentrating on the following five core services:

- Urgent & emergency services

- Medical care (including older people’s care)
- Maternity and gynaecology
- End of life care.

# Summary of findings

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a much defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held five focus groups with a range of staff from across the hospital who worked within the service. In total, around 60 staff attended all those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out unannounced visits on 30 December 2016 and the 3 January 2017.

## What people who use the trust's services say

The trust's Friends and Family Test performance (% recommended) was generally better than the England average between September 2015 and August 2016. In the latest period, August 2016 trust performance was 98.5% compared to an England average of 95.2%.

In the Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for none of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for six questions. The trust scored in the bottom 20% of trusts nationally for questions relating to privacy and dignity, however 92.8% of respondents still felt they were given enough privacy (the boundary of the top 20 trusts was 96.2%). The trust also performed poorly for choices of treatment, confidence in their doctors, and for respondents' families being able to talk to doctors. In the 2015 survey, 16 of the trust's scores had improved on the previous year; the other 18 were worse.

The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness, Food, and Facilities. The trust performed worse than the England average in assessments relating to Privacy, Dignity, and Wellbeing. Between 2015 and 2016, trust scores improved for Cleanliness and Food, and particularly for facilities (an increased in score of 10%); however scores for Privacy, Dignity and Wellbeing fell by 9% during this time.

In the CQC Inpatient Survey 2015, the trust performed within expectations for all of the eleven questions for which data were available (no figures were available for "on the day you left hospital, was your discharge delayed for any reason?"). All of the trust's scores for the 2015 survey improved on its 2014 scores.

# Summary of findings

## Facts and data about this trust


The trust's main CCGs (Clinical Commissioning Groups) are NHS Shropshire CCG and NHS Telford and Wrekin CCG and NHS England North Midlands. The trust primarily serves a population of approximately 500,000 in Shropshire, Telford, Wrekin and mid Wales.

During 2015/16 the trust had 116,154 inpatient admissions, 407,108 outpatient attendances and 121,105 attendances in the emergency department.

For most of the period Q3 2015/16 to Q2 16/17, bed occupancy was greater than 90%; this was also consistently higher than the England average. The exception was in Q2 15/16, when it fell to 86.4% (England average 87%).

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p><b>We rated safe as requires improvement because:</b></p> <ul style="list-style-type: none"><li>• Nurse staffing levels were planned but did not take into account the acuity of patients or the demand for services.</li><li>• There were insufficient numbers of emergency department consultants for the size of the department, consultants work excessive hours to ensure care was delivered</li><li>• The trust was below the national average for junior medical staff</li><li>• There was a heavy reliance on agency and locum staff to ensure that shifts were filled</li><li>• Mandatory training compliance did not meet the trust target of 100%</li></ul> <p>However:</p> <ul style="list-style-type: none"><li>• Staff were encouraged to report incidents and felt able to do so. Incidents were investigated and reviewed for learning, although wider learning was not always shared</li><li>• Staff and managers understood their responsibilities under Duty of Candour regulations</li><li>• There were effective systems and processes to ensure that vulnerable adults and children were safeguarded.</li></ul> <p><b>Duty of Candour</b></p> <ul style="list-style-type: none"><li>• The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.</li><li>• We saw that the trust had a process in place to fulfil its obligations in relation to the Duty of Candour regulations.</li><li>• There was evidence that the trust was open and honest with patients in the serious incident investigation reports we reviewed. Records showed that a formal apology had been given as required, along with an explanation of the actions that would be taken to prevent the issue happening again.</li><li>• In 2015, the trust commissioned an independent investigation into an avoidable baby death in 2009. We saw that the Chief Executive had made a full public apology to the family and this</li></ul>	<p><b>Requires improvement</b> </p>

# Summary of findings

was a matter of record in the trust board papers. The trust acknowledged that it had failed to recognise their failings earlier and was taking the recommendations from the review and the family very seriously.

- The majority of staff we spoke to were aware of the need to be open and transparent under the Duty of Candour regulations, some were able to cite examples of where it had been applied.

## Safeguarding

- There were trust-wide safeguarding policies and procedures in place for both vulnerable adults and children, which were supported by staff training.
- The trust's target for completion of safeguarding training was 100%. Data provided by the trust showed that at a trust wide level the completion rates for safeguarding children and adults level one was 100%, safeguarding children and adults level two was 68% and safeguarding children level three was 92%.
- Staff we spoke to were aware of their roles and responsibilities and knew how to raise matters of concern appropriately, including issues relating to domestic violence, child sexual exploitation and Female Genital Mutilation (FGM).
- The trust had a safeguarding lead for vulnerable adults and children with one additional member of staff to assist them with all safeguarding alerts. The Director of Nursing was the member of the board with a responsibility for safeguarding.
- The trust had no dedicated email for safeguarding enquiries with any safeguarding concerns sent to either of the safeguarding leads trust email address. There was a risk that there may be a delay responding to any safeguarding concerns.
- Staff had access to senior nurses within the hospital management team outside of normal working hours and at weekends to seek advice and guidance on safeguarding issues.
- In maternity services, midwives were able to make referrals to the Supporting Women with Additional Needs (SWAN) pathway. The SWAN group met monthly. Meetings were chaired by the safeguarding lead midwife and attended by multi-disciplinary professionals including health visitors, family nurses, teenage pregnancy specialist midwives and community midwives. We saw meeting minutes, which showed discussion of new referrals and high-risk cases. The trust had recently provided safeguarding supervision training to 10 midwives with a plan to increase the number in the future. Staff told us this was a positive step to provide support to midwives in this area, which can be emotionally challenging. There were safeguarding link midwives in all ward areas to support the safeguarding team and to increase midwife skills and competence in this area.



# Summary of findings

## Incidents

- The trust had a policy and an electronic system for the reporting and management of incidents. Incident reporting was embedded in the organisation
- Staff in all the areas we inspected were aware of the types of incident they should report and told us they were encouraged to do so. They were able to give us recent examples where they had reported them. Staff told us they generally received feedback when they had reported an incident, but did not hear about incidents and the outcomes in other part of the hospital or trust.
- In accordance with the Serious Incident Framework 2015, the trust reported 61 serious incidents (SIs) which met the reporting criteria set by NHS England between November 2015 and October 2016 Of these, the most common type of incidents reported were surgical or invasive procedure incidents (21%), pressure ulcers meeting SI criteria (16%) and diagnostic incidents (16%). (Source: Strategic Executive Information System (STEIS))
- There were 5037 incidents reported to NRLS between September 2015 and August 2016; the proportions of incidents by severity were: five deaths this was the same as the England average, the proportion of incidents which were classified as severe was higher than the England average (0.5% compared to the England average of 0.3%).
- During this period NRLS incidents were reported at a rate of 5.6 per 100 admissions, this was lower than the England average of 8.6 per 100 admissions.
- We saw that incidents were routinely investigated and action plans for learning developed as a result.
- Data from the Patient Safety Thermometer showed that the trust reported 76 pressure ulcers, 26 falls with harm and 51 catheter urinary tract infections between September 2015 and September 2016.
- We noted on some wards that the most up to date safety thermometer data was not displayed. The specific maternity safety thermometer was not being used by the trust.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between November 2015 and October 2016, the trust reported five incidents which were classified as Never Events. Four of these involved a surgical or invasive procedure and one related to a retained foreign object.

# Summary of findings

- There was one case of MRSA reported between September 2015 and August 2016. All NHS trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 22 MSSA infections and 18 C.Difficile infections over the same period.
- The trust reported one active mortality outlier alerts as at October 2016. At the time of the inspection, CQC's expert panel were considering the alert for follow up. The alert related to fluid and electrolyte disorders.

## Mandatory Training

- The trust's corporate education department provided mandatory training days for nurses and for doctors working in ED. Their target for completion of this training was 100%.
- Mandatory training which included manual handling, fire safety, basic life support, information governance and infection control was completed annually.
- Training records we looked at showed a wide variance between wards and departments in completion rates, none of the core services we inspected met the trust target. Overall compliance was below 80%. Key challenges are service pressures resulting in staff not being released for training. The trust had recently introduced monthly reporting to line managers in an attempt to improve compliance.

## Staffing

- There was no nationally recognised tool to assess the number of nursing staff required in emergency departments (ED). Managers assessed staffing requirements based on expected local peaks and troughs in demand and historic data.
- Nursing staff levels in the EDs were generally achieved, with a heavy reliance on bank and agency staff. For example, in June 2016, 98% of rostered shifts were covered at Royal Shrewsbury but to achieve this, the department had used eight times as many bank and agency nurses as had been planned and budgeted for.
- The trust had a 6% ceiling on nursing agency spend (2016/2017). The board report identified in December 2015 this ceiling was exceeded by 2.87%.
- The Royal College of Emergency Medicine suggests that 16 consultants were needed to safely run each of the departments. The trust had six substantive ED consultants shared between the two departments. Two consultants worked only at the Princess Royal whilst the others were rostered between the two sites.

# Summary of findings

- Two consultants told us they were supposed to attend between 9am and noon on weekends, to carry out ward rounds in ED and the clinical decisions unit. However, they said they rarely left the department before 5pm and were then frequently called back in overnight. They told us this level of pressure was unsustainable.
- The trust was also short of middle grade doctors in both EDs and relied heavily on locums to cover shifts. Consultants told us the trust supported them well with requests for locums, but recruitment was problematic. On 12 nights in September 2016, one of ED's consultants had to cover a night as no locum could be found to work the shift.
- In June 2016, the proportions of consultant staff and junior doctors reported to be working at the trust were lower than the England average with only 20% consultants.
- The hospital used safer nursing care tool (SNCT) in all areas as part of a six-monthly staffing establishment review carried out in medical services to determine staffing levels. However, this did not assess the required staffing numbers for the dependency of the patients on each ward. It used the previous months staffing levels to project the likely need for that month. Within each Care Group, a senior nurse leader took an overview and coordinated the staffing requirements and redeployed staff according to the needs of the wards.
- Planned and actual numbers of staff were sometimes but not always displayed on the wards and not always for the correct day.
- Average fill rates for registered nurses in November 2016 on the medical wards were around 90% during the day and closer to 100% at night. To achieve this wards relied on agency and bank staff to cover the gaps.
- We noted on some wards we visited that although the planned staffing level was being met, the number of staff on duty was inadequate for them to complete all of their necessary duties within their shift and patients were subject to delays in care or some needs were not being met. On one ward, we escalated our concerns and an additional nurse was provided to assist from another ward.
- Agency and bank staff use was reported as high due to staff vacancies and levels of staff sickness across all the wards we visited. For example, the surgical assessment unit at Royal Shrewsbury had 10 staff nurse vacancies. Absence of staff was covered by block booked, regular bank or agency staff where possible.
- The trust had recently commissioned a 'Birth-rate Plus' workforce planning review in maternity services and the results

# Summary of findings

were expected in early 2017. The National Institute for Health and Care Excellence (NICE) endorsed this tool. Birth-rate Plus will determine the trust's maternity staffing requirements to ensure safe care.

## Are services at this trust effective?

### We rated effective as good because:

- People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This is monitored to ensure consistency.
- Outcomes for people who use service were generally positive and mostly met expectations.
- We saw that staff worked collaboratively to understand and meet the needs of patients.
- Most staff were able to demonstrate a good understanding of their responsibilities around consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.

### However:

- We reviewed 12 defined ceiling of treatment forms for patients who staff had deemed as lacking capacity and found consultants had not completed mental capacity documentation. This was supported by the trust's own audit findings.
- The trust scored below the national average on all five clinical quality indicators and met only one in eight of the organisational benchmarks set in the national End of Life Care Audit.

### Evidence based care and treatment

- We saw that clinical guidelines and policies were based on NICE and Royal College guidelines were available for the staff and accessible on the intranet. The trust carried out audits to ensure staff were complying with policies and procedures.
- Care pathways ensured that best practice was followed. For example, in the management of fractured neck of femur. Care pathways in accident and emergency were based on national Royal College clinical guidance and best practice. These included the 'sepsis six' pathway, which assisted staff to identify and provide appropriate treatment for patients presenting with sepsis symptoms. Pathways for paediatric patients in accident and emergency were based on the Royal College of Paediatric and Child Health guidance
- In theatre, we observed staff following post-anaesthesia care unit (PACU) handover checklist. After general, epidural or spinal

Good



# Summary of findings

anaesthesia, patients were recovered in a specially designated area. We observed the anaesthetist formally handing over the care of a patient to the nurse using the PACU checklist, which included a three part handover; patient, procedure and medication.

- A personalised end of life care pathway was introduced after our last inspection in 2014, following the withdrawal of the Liverpool Care Pathway. The pathway had been developed across all health services within Shropshire. It supported patients in the last few days and hours of life only.

## Patient outcomes

- The trust were not outliers for any clinical procedures within either emergency department. This meant that clinical outcomes were within NHS England expectations.
- In medicine, most patient outcomes were similar to or better than national targets. Where outcomes were lower, there was evidence of action to improve.
- National 'bowel cancer audit' performance was recorded as 100% in 2016. A clinical nurse specialist saw 98% of patients, which was above the national average of 92%.
- Despite high levels of activity within the maternity consultant led unit (CLU), the trust was achieving higher than average vaginal birth rates. The caesarean rates were below (better than) the trust and national targets.
- The trust was working to improve care for patients, working in partnership with the Virginia Mason Institute (VMI) as part of a five-year plan. The trust had completed work on respiratory care and had been able to demonstrate a positive impact on patient outcomes. Staff reported a 98% reduction in time from patients arriving on the respiratory ward to the point they were informed of a plan/date for discharge (1229 to 20 minutes) and a reduction from 540 to 50 minutes to commence the fact finding assessment.
- We reviewed the results from the 'Royal College of Physician's' End of Life Care Audit: Dying in Hospital, dated March 2016. The audit presents the results of the second biennial national audit of care of the dying in hospitals in England. At the time of participation (2015), the trust scored below the national result average on all five clinical quality indicators and met only one in eight of the organisational benchmarks set.
- At the time of our inspection (December 2016), we saw there was an action plan in place to address the findings of the audit

# Summary of findings

and that the trust were working hard to improve EoLC. For example, we saw the hospital had implemented a bereavement survey and that the End of Life Facilitator was rolling out training on the End of Life Plan.

## **Multidisciplinary working**

- There was evidence of good multidisciplinary team working in all the wards and departments we inspected. Staff told us that this approach was part of the culture of the trust.
- We saw how different specialities worked together to support patients. Nursing staff and doctors worked closely together with therapists. The communication between all staff was good.
- We observed several handover meetings and board rounds across different core service areas. We saw that there were staff from all areas that were involved in patient care and that they had input to the meetings and care was coordinated.

## **Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

- Senior staff demonstrated good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw that there were good templates to follow for assessment of capacity.
- Most staff we spoke with across the trust were able to describe how they ensured patients had capacity to consent to procedures provided. However, a few staff showed a lack of understanding about their role with assessing capacity and what the protocol was for medical staff involvement and at what stage an assessment should take place. For example we saw a patient who required assessment for capacity however, the relevant paperwork had not been completed for over 24-hours as staff on the ward were waiting for a Doctor to complete this.
- On the elderly care wards, we saw good examples of mental capacity act (MCA) and deprivation of liberties (DoLs) assessments being completed, staff had a good understanding of MCS and DoLS and could give examples of when they had needed them in order to safeguard a patient.
- There was a range of information for staff to refer to when making decisions around capacity. We saw leaflets and information for staff, a specialist could be contacted for advice and policies were available through the trusts intranet.
- We reviewed 12 defined ceiling of treatment forms where doctors had recorded patients as lacking capacity and found doctors had not completed the required mental capacity

# Summary of findings

documentation. Additionally we found instances where patients had been deemed as lacking capacity to make or communicate decisions about their future care and treatment by a doctor no discussion with relatives had been recorded.

- The trust completed an audit programme on the completion of 'defined ceiling of treatment' forms in June 2016. The audit highlighted that in 90% of cases when the patient lacked capacity, the appropriate mental capacity documentation was not in place.

## Are services at this trust caring?

### We rated caring as good because:

- Patients consistently told us that staff cared for them well with compassion and kindness.
- We saw examples of good care being given on every ward and department we visited.
- The NHS Friends and Family Test (FFT) survey results were better than England averages.
- We saw that patients were included in decisions about their care and treatment
- Staff were able to provide patients and relatives with emotional support and arrangements were in place to provide spiritual and psychological support where needed.

### Compassionate care

- During the inspection, we saw that all clinical and non-clinical staff treated patients and their relatives with compassion and respect. Privacy and dignity was maintained when staff provided personal care.
- The trust participated in the NHS Friends and Family survey. The percentage of patients who would recommend services were generally better than the England average between September 2015 and August 2016. In August the trust performance was 98.5% compared to an England average of 95.2%.
- Between October 2015 and September 2016, the results for the antenatal care survey showed that 97% of women who participated would recommend the service to their family and friends. The results for women who had received postnatal care were 99% and 100% of women who had used it to give birth would recommend the service.
- From September 2015 to September 2016, Friends and Family survey results for both of the emergency departments in the

Good



# Summary of findings

trust as a whole varied between 90% and 95% of patients who would recommend the services to family or friends. This was consistently better than the average response for all England emergency departments.

## **Understanding and involvement of patients and those close to them**

- Patients generally told us they had felt involved in their care and treatment, were given the opportunity to ask questions and were given sufficient information to answer their concerns
- Women told us that they were involved and in control throughout their pregnancy journey to identify what would make their hospital stay more comfortable.
- We saw that when talking to patients, staff gave clear explanations in a way people could understand.

## **Emotional support**

- We observed effective emotional support from staff on the wards and in departments where patients felt unsettled or anxious about their treatment.
- The trust operated a chaplaincy service, with on-call multi faith chaplains available out of hours via the hospital switchboard. The hospital had a multi faith chapel, which was available for patients, staff and visitors 24 hours a day, seven days a week.
- Clinical nurse specialists were available to provide support and expert advice related to specific conditions or treatment pathways.
- There was an effective process in place to ensure the emotional and psychological wellbeing of pregnant and postnatal women was explored. Mental health questions were mandatory as part of the booking appointment and at intervals through the pregnancy.
- Bereavement counselling was available for staff to refer women to if they required following the loss of a baby.

## **Are services at this trust responsive?**

### **We rated responsive as requires improvement because:**

- The hospital was consistently failing to meet the NHS England target that 95% of patients who attend emergency departments are admitted, transferred or discharged within four hours.
- The trust's referral to treatment time (RTT) was 73.8%, this showed that the trust was failing to meet the 90% treatment target.

**Requires improvement**





# Summary of findings

- The capacity of the two emergency departments was always not meeting the growth in demand for patient services, the trust were aware of this and reviewing urgent care provision
- Translation services were available for patients whose first language was not English but were not always used effectively.

However:

- There were good arrangements in place for patients living with dementia
- Complaints are responded to in a timely way, staff take complaints seriously and make changes to services as a result.

## **Service planning and delivery to meet the needs of local people**

- Between 2006 and 2016, attendances at the trust's two emergency departments had increased by 12%, with an increase of 7% from 2014/15 to 2015/16 alone. Consultants and managers told us the emergency department at Princess Royal Hospital could not meet the demands of a growing population created by expanding urbanisation. The trust board recognised the existing emergency departments could not cope with the increased number of patients and were no longer fit for purpose.
- Plans to restructure emergency care provision across the county were in consultation as part of the NHS 'Future Fit' programme, which took into account the changing demographic of patients in the area served by the trust.
- Paediatric emergency services were based at Princess Royal Hospital although there was not a separate paediatric emergency department for children and young adults. A small, child-friendly waiting room was available with play equipment and murals to distract and entertain very young children.
- The maternity service was undergoing a high-level review to improve maternity services across Shropshire and Mid-Wales. Senior midwifery managers identified the need for review based on 85% of birth activity occurring within the consultant-led unit despite the trust having the facility of five MLUs. Midwifery managers including the head of midwifery and the care group director developed a paper setting out revised potential care models in view of the increase in activity in the consultant-led unit and therefore reduced in the MLUs.

## **Meeting people's individual needs**

- For patients with a learning disability, staff could access the learning disability link nurse and were aware of reasonable adjustments to support these patients.

# Summary of findings

- Staff told us and we saw that the trust had telephone based translation services available for patients whose first language was not English. Many staff told us the service was accessible when needed however, we observed specific situations in both emergency departments when the translation service was not used, where it would have been appropriate to do so. Staff told us they did not access the service because they did not have the necessary password or they were not aware of the service.
- The trust had rolled out the “Swan scheme”, providing resources for staff and practical measures for patients who were at the end of their lives and their families which included swan boxes, bags and end of life information files for staff.
- At Royal Shrewsbury, there were three Swan Rooms, which provided a suitable environment for patients to be cared for at the end of their lives. Ward staff told us they had received positive feedback from family members.

## Dementia

- The Butterfly Scheme allowed people with memory impairment to make their needs clear to staff and receive a form of personalised care during their stay in hospital. It also reminds staff of how to interact and communicate with people living with dementia and to include their families and carers in the process, in order to reduce stress and anxiety. We saw the Butterfly scheme employed on all the wards and departments we visited to good effect.
- The trust had improved the environment on some wards to make them dementia-friendly. For example, on the elderly care ward at Royal Shrewsbury, a room had been transformed into a 1950’s style living room, providing dementia care patients with a nostalgic atmosphere which aided relaxation.
- The trust ran one and two-day dementia awareness courses for staff and we met link nurses on wards who had a role in educating and supporting their colleagues. Dementia awareness was part of the staff induction process.
- On-going promotion of the carers passport and the “This is Me” document improved care for patients with dementia and their carers by focusing on personalised assessment and care plans. Staff provided patient passports to patients living with dementia. This provided information about patients so that staff knew more about them such as their likes and dislikes and hobbies.

## Access and flow

- The Department of Health’s standard for emergency departments is that 95% of patients should be admitted,

# Summary of findings

transferred or discharged within four hours of arrival in ED. From December 2015 to December 2016 the trust did not achieve this target. On average, 81% of patients were admitted, transferred or discharged from its two emergency departments during this time, which was worse than the England average of 89% for the same period. Data for the individual departments was not available.

- The Royal College of Emergency Medicine recommends the time patients should wait from the time of arrival to receiving treatment should be no more than one hour. The trust did not report on each of its two emergency departments separately so we were not able to assess how ED at Royal Shrewsbury Hospital was performing. Overall, from August 2015 to July 2016 the trust met the standard for seven out of 12 months. In July 2016 the median time to treatment across the two departments was 66, compared to the England average of 62 minutes.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015. The latest figures for August 2016 showed 73.8% of this group of patients were treated within 18 weeks. This showed that the trust was failing to meet the 90% treatment target.
- Between January and November 2016, general surgery 'admitted performance' ranged between 61% and 86%. Within the same timescale, oral surgery 'admitted performance' ranged between 14% and 50%, which was due to a historic backlog with commissioning. Orthopaedics 'admitted performance' ranged between 38% and 60%.
- Some surgical specialties were above the England average for admitted RTT (percentage within 18 weeks). Ophthalmology scored 84.4% with the England average score being 80.1%. This also showed that the trust was failing to meet the 90% treatment target, which we were told was the result of two doctors being excluded and one dismissed.
- Bed occupancy of the trust between April 2016 and September 2016 was 92.3% which was higher than the national average. The accepted level at which bed occupancy can start to affect the quality of care afforded to patients and the systematic running of a hospital is 85%. Consultants told us that the hospital was always full and ring fencing beds was an issue.
- The trust had a system of 'boarding' when all beds were occupied and there were large numbers of patients waiting for a bed. 'Boarding' was accommodating patients in additional areas which would not normally accommodate a patient, such as alongside the nursing station and the head and neck theatre

# Summary of findings

recovery. Executive directors said they disliked using boarding but when capacity of beds was exceeded and when specific criteria and risk assessment was followed they felt it provided the safest option for patients.

## Learning from complaints and concerns

- The trust had a complaints policy which was available to staff on the intranet
- The trust website also contained information about PALS and how to raise concerns or complain.
- Posters and leaflets about raising complaints or concerns were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint.
- Although staff told us they received feedback from complaints raised in the area they worked in, they did not receive information about concerns from the wider trust or services and so the opportunity to learn from these was missed.
- We met and spoke with a Patient Advice and Liaison Service (PALS) advisor. They offer confidential advice, support and information on health-related matters; providing a point of contact for patients, their families and their carers. We discussed the lack of complaint advice notices seen around the hospital and were told a delivery was imminent.
- During 2015/2016, the trust received 317 formal complaints. 26% were fully upheld by the trust, 34% were partly upheld and 39% not upheld. The most common theme was clinical care; this accounted for 51% of all complaints during the period.
- The Trust policy states that all complaints should be acknowledged within 3 working days of receipt. Data we saw showed that this was achieved in all (100%) of cases. For the majority of complaints the Trust aims to respond within 30 working, unless it is more complex, in which case a response time is agreed with the complainant. During 2015/2016, the trust responded to 90% of complaints within the timescale initially agreed.

## Are services at this trust well-led?

### We rated well-led as requires improvement because

- Some local leaders expressed concerns that senior leaders did not understand the day to day pressures of the service they delivered.
- Clinical leadership in the emergency department at Princess Royal had not addressed differences in key working practices.

Requires improvement



# Summary of findings

- A culture of learning for safety incidents was still in the process of embedding in maternity services although the new leadership team were making good progress.
- The trust needed to do further work on equality and diversity
- The NHS staff survey engagement score was worse than the average when compared with trusts of a similar type and the trust scored below the England average on a range of indicators.

However:

- There was a clear statement of vision and values, which focus on quality and safety. Staff understand the vision and values and the role they have to play in achieving them.
- Leaders within the trust have a good grasp of the strategic issues facing the organisation and have clear plans on how to address them
- There is a clear structure for governance that worked effectively at a number of levels through the organisation.
- There has been a positive change in culture since our last inspection, staff feel more engaged and valued.
- The current trust leadership team demonstrated a focus on the issues that impacted on the trusts clinical delivery.
- There is a strong focus on innovation with the transforming care institute work.

## Leadership of the trust

- The trust has a relatively new executive team. The chief executive took office in 2015 whilst the chair has been in post since 2013. The director of nursing and medical director were also appointed in 2013. The chief operating officer has been at the trust since 2012, and the finance director is the longest standing member of the executive team (since 2011). The director of nursing at the time of the inspection was leaving her post after the inspection in January 2017.
- Two deputy medical directors had been in post since August 2016 and had four sessions each week to undertake these roles. They each had identified remits. One deputy director led on transformation, the other on quality and safety. The deputy directors provided cross working, engagement and communication across care groups and were an interface between doctors and the executive. They saw the role as impartial and providing robust challenge.
- The leadership of clinical services across both hospital sites was provided through four care groups for unscheduled care

# Summary of findings

(medicine and emergency services), scheduled care (surgery), women and children's and support services. Each care group has triumvirate management arrangement with a business leader, clinical leader and nursing/midwifery leader.

- Senior leaders demonstrated a good grasp of the issues facing the organisation and the challenges they were facing in terms of managing demand and the sustainability of the current configuration of services. They displayed a willingness and drive to engage with local stakeholders and the wider community to ensure services reflected local need.
- There was a new leadership team in the maternity services, they had made positive steps in improving services and embedding a culture of safety, but there was still some work to do.
- We saw that clinical leadership in the emergency department had not addressed differences in working practices by consultants working at the Princess Royal site. This affected the patient experience in the department and did not create a harmonious atmosphere for staff.
- We saw good local leadership on the wards and in the departments we visited. Staff told us they felt supported by and listened to by their immediate line managers and spoke highly of them. Some local leaders told us they felt supported by senior managers but were unsure if the senior leaders understood the day-to-day pressures. Some staff commented to us that they did not feel the executive team were visible or they could easily take issues to them directly.
- The trust runs a leadership conference, with over 220 staff attending the last event.

## **Vision and strategy**

- The trust had a clear vision and set of values, which were widely publicised to staff and patients around the hospital sites as well as on the intranet and trust website. The values were – Proud to CARE, make it HAPPEN, we value RESPECT and together we ACHIEVE. Staff we spoke to were aware of the vision and values and related to the message behind them.
- The trust also has a clear organisational strategy, based on the vision and values. The strategy sets out the trust will deliver “the safest and kindest care in the NHS” to the population it serves. This strategy was developed with the involvement of staff and service users.
- The strategy acknowledges that the current configuration of hospitals does not meet the demands put upon it and the work that is going on and needs to be completed both within and

# Summary of findings

outside the trust to ensure services are sustainable. At the time of the inspection, the trust had out together an outline business case for a single site emergency service at one hospital and planned care at the other.

- We also saw there were system wide reviews taking place for a number of services/specialties such as orthopaedic care and maternity services. Some of these reviews were unsettling for staff and having an impact on staff morale.

## **Governance, risk management and quality measurement**

- Governance systems were in place to identify risks and provider quality oversight. There were clear governance arrangements within each Care Group, which worked well and fed into trust-wide arrangements. Board papers we reviewed showed that quality and safety were high on the agenda; each meeting includes a patient story, and evidence from our interviews with them supported this.
- The board of directors and executive level director groups received monthly performance reports on national and local targets. Action plans were put in place to improve performance where needed across the medical directorate.
- The board integrated performance report includes performance against key national targets, quality and safety targets as well as workforce and financial targets. The report also details learning from root cause analysis reports (RCA) completed since the last board report. This gives the board oversight of key issues and encourages learning. Directors we spoke with told us they felt that learning from incidents could be improved even further but felt that RCA investigations were done well.
- We saw that all the services we visited held local risk registers, which fed into the corporate risk register. The board assurance framework reflected some of the concerns from our inspection. This included delivery of safe care – through delivery of a range of service reviews including maternity and ophthalmology; delayed transfers of care; risk to sustainability of clinical services due to shortages of clinical staff and patient flow.
- In 2015, the trust commissioned an independent review into the avoidable death of a baby in 2009. The final report was completed in November 2015. This was presented to the public trust board meeting in April 2016 and subsequently published on the trust's website. The family were invited to the meeting. At that meeting the Chief Executive made a full public apology to the family and this was a matter of record in the trust board papers.
- Since the publication of the review, the action plan resulting from the recommendations has been monitored on a monthly

# Summary of findings

basis by the quality and safety committee with regular updates to the trust board. The director of nursing oversaw the process, ensuring the family were involved throughout. During our inspection, we saw that the trust had made positive progress on seven of the nine recommendations made in the report and action were in place to complete the outstanding two actions.

- We reviewed five investigation reports, relating to the deaths of babies at the trust since our inspection in 2014. Although we could see that the investigations had been undertaken in a robust manner actions from some of the finding were not in a timely manner and not fully embedded in the service.

## **Culture within the trust**

- Across all the areas we visited, we saw a positive change in culture amongst staff and leaders since our 2014 inspection. There was an increasing atmosphere of openness, honesty and candour and this was being driven by senior leaders.
- Patient care was clearly a high priority for staff and they were proud to talk about where they worked. We saw and heard that staff felt respected and valued. The contribution of staff was important to the on-going transformation work and they were enthusiastic and energised by the process. We observed good team working and a positive approach for all staff we met.
- Some staff told us they were empowered to raise concerns but were frustrated that issues such as staff shortage, ward environment improvements and some training issues were not addressed.

## **Equalities and Diversity – including Workforce Race Equality Standard**

- As part of the new Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. The WRES has nine specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of its Black and Minority Ethnic (BME) staff. As part of this inspection, we looked into what the trust was doing to embed the WRES and race equality into the organisation as well as its work to include other staff and patient groups with protected characteristics.
- The equality & diversity function was overseen by the Workforce Director. The trust published its WRES Report as required by NHS England, with regular updates to the board throughout the year.
- The trust's 2016 WRES report shows that there is a 10.02% BME representation in the overall workforce.



# Summary of findings

- The report also showed that BME staff were four times as likely to be subject to formal disciplinary proceedings when compared to white staff. The trust stated that during the review period there were a number of investigations involving medical staff. They have a higher BME representation than the rest of the organisation (33%).
- Across the trust, the report showed that white candidates that are shortlisted to vacant roles were 1.11 times more likely to be appointed than BME candidates.
- The trust acknowledges it needs to do more work in this area, especially around the number of BME staff reporting they have been subject to abuse, compared to white colleagues and the proportion of staff subject to disciplinary, when compared to white colleagues. The trust have taken specialist advice from NHS Employers and developed an action plan to tackle these issues.

## Fit and Proper Persons

- The trust was aware of its obligations in terms of the fit and proper persons regulation. This regulation ensures that directors of NHS providers are of good character and have the appropriate skills and background to carry out their roles.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, employment history, professional registration and qualification checks.
- Recruitment processes were in place and included relevant personal, professional and financial checks.

## Public engagement

- The trust had a Patient Experience Involvement panel known as PEIP. The PEIP bring together patients and carers to shape the trust plans for improving patient experience, gathered feedback directly from patients
- Patients and local people can also get involved in the trust by becoming a member of the NHS Foundation Trust. There are over 9,000 members. The trust consult with the public members on the future development of our services and invite them to focus groups, workshops and special interest groups. Each member also receives a newsletter called “A Healthier Future”.
- They were also included in ward visits known as ‘GEMBA’ walks. PEIP member we spoke to told us that they had an allocated ward that they were able to visit at any time to review patient experience.
- The trust also engages with the public through volunteers, there were approximately 800 at the trust. We saw the role of

# Summary of findings

the volunteer was a vital role within the medical directorate, for example. They were involved in a wide range of areas including chaplaincy, ward helpers, dementia activities and mealtime buddies.

- Friends and Family Test data for inpatients in December 2016 showed that 98% of patients would recommend the service, which was better than the England average. The response rate was 15.9% which was below the England average.

## Staff engagement

- In the 2016 NHS staff survey, the overall indicator of staff engagement score was 3.75. This was below (worse than) the average when compared with trusts of a similar type (3.81). The trust scored 3.73 in 2015.
- The trust scored in the bottom 20% of similar trusts when staff were asked if they would recommend it as a place to work (56% compared to the England average of 62%) or receive treatment (62% compared to the England average of 70%). When asked if care of patients was a priority for the trust, 68% of staff responded positively compared to the England average of 76%.
- The trust scored below average when asked about the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs. However, there had been a significant improvement in staff ability to contribute towards improvements at work.
- The staff Friends and Family Test data for July to September 2016, showed of the 140 respondents, 65% would recommend it as a place to work and 80% would recommend it as a place to receive care.
- Staff told us they received the trust's newsletter by email, and were kept up to date with local issues through team meetings, information posters and presentations delivered by leaders.
- The VIP (Values In Practice) Awards was a trust-wide scheme to acknowledge the outstanding achievements and contributions made by clinical and non-clinical staff. Every month, each care group at the trust put forward their own monthly VIP Award winner from all those nominated, and each one is then considered for the overall monthly award. We saw staff members had been put forward for this award on some of the wards/departments we visited.

## Innovation, improvement and sustainability

- Plans to restructure emergency care provision across the county were in consultation as part of the 'Future Fit' programme, which took into account the changing

# Summary of findings

demographic of patients in the area served by the trust. Changes proposed by the programme included retaining services at both Princess Royal Hospital and Royal Shrewsbury Hospital as urgent care centres, and creating one new, purpose-built emergency centre in the county.

- The Virginia Mason Institute (VMI) designed and developed its systems to become widely regarded as one of the safest hospitals in the world. The trust embraced these methodologies and in partnership with VMI, they have developed new initiatives within the hospital. They used the model to create the transforming care institute (TCI). TCI wants an effective approach to transforming healthcare by coaching teams and facilitating continuous improvement.
- The trust was working to improve care for patients who suffered from sepsis and were using techniques learned from the Virginia Mason Institute (VMI) as part of a five-year partnership. Sepsis arises when the body's response to an infection injures its own tissues and organs. It leads to shock, multiple organ failure and death, especially if staff do not recognise symptom early and treat it promptly. The trust had held two weeklong workshops that focused on making small but significant and sustainable improvements. The most recent of these showed it was possible for patients to receive all parts of the life-saving medication 'Sepsis 6' bundle in less than one hour, which evidence shows increases survival rates.
- The trust had only achieved the results on a relatively small number of patients to date. However, the trust planned to continue testing the changes by measuring results on a monthly basis. The person in charge of the first Sepsis Value project, found that when challenged to improve screening and recognition of sepsis some people did not have a clear understanding of what sepsis was. To combat this, the trust produced a simple leaflet that explained what sepsis was along with an informative quiz to ensure staff retained the information learned in the leaflet. The information leaflet proved to be a success and the trust had shared it with The UK Sepsis Trust and a number of other trusts.
- The trust was in the process of undertaking a ward accreditation programme known as Exemplar. The Exemplar philosophy is to deliver excellence in the quality of care all day, every day for every patient, every time. The exemplar status will be gained by demonstrating performance against a series of quality improvement measures. The framework was designed to incorporate elements of care, efficiency and effectiveness,

# Summary of findings

patient experience, environment and leadership. The trust identifies that the outcomes should be more contact time with patients, more work clinically and patients should feedback a more informed stay and positive experience.

# Overview of ratings

## Our ratings for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
<b>Overall</b>	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

## Our ratings for Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
<b>Overall</b>	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# Overview of ratings

## Our ratings for Bridgnorth Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

## Our ratings for Ludlow Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

## Our ratings for Oswestry Maternity Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

## Our ratings for Shrewsbury and Telford Hospital NHS Trust

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

# Outstanding practice and areas for improvement

## Outstanding practice

- Virginia Mason Institute (VMI) designed and developed its systems to become widely regarded as one of the safest hospitals in the world. The trust embraced these methodologies and in partnership with VMI, they have developed new initiatives within the hospital. They used the model to create the transforming care institute (TCI). TCI wants an effective approach to transforming healthcare by coaching teams and facilitating continuous improvement.
- The trust had rolled out the Swan scheme across the trust which included a Swan bereavement suite, Swan rooms, boxes, bags and resource files for staff.
- The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life patient.
- Staff told us that if the bereavement office arranged a viewing in the mortuary they would walk the relatives to the mortuary. If the mortuary department arranged the viewing, they would meet relatives at the main entrance and walk them to the mortuary department.

## Areas for improvement

### Action the trust MUST take to improve

- The trust must ensure there are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients
- The trust must ensure all patients brought in by ambulance are promptly assessed and triaged by a registered nurse.
- The trust must ensure a suitably qualified member of staff triages all patients, face to face, on their arrival in ED by ambulance.
- The trust must review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times.
- The trust must ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery.
- The trust must ensure that all staff are up to date with mandatory training
- The trust must ensure patient information leaflets can be provided in languages other than English.
- The trust must ensure staff have access to a translation service, and that all staff are aware of the service.
- The trust must ensure relevant learning from incidents is shared across all departments at all its sites.
- The trust must ensure that all staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required.
- The trust must ensure ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients with four hours of their arrival in the department.
- The trust must ensure sufficient emergency equipment is available to respond to emergencies.
- The trust must ensure the application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist is improved in theatres
- The trust must ensure that up to date safety thermometer information is displayed on all wards
- The trust must ensure the theatre storerooms are suitably maintained and regularly cleaned.
- The trust must ensure equipment in theatres is repaired or replaced as required to ensure it is fit for purpose and keeps people safe.

# Outstanding practice and areas for improvement

- The trust must ensure medication refrigerators temperatures are recorded daily and appropriate action is taken when temperatures fall outside accepted parameters.
- The trust must ensure patient medical records are kept secure in all areas at all times
- The trust must ensure all theatre recovery staff have completed advanced life support training as per national guidance
- The trust must ensure they are preventing, detecting and controlling the spread of infections, including those that are health care associated in the mortuary department.
- The trust must ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning.
- The trust must review the security of access from the public waiting area into the resuscitation, majors and minors patient treatment areas to ensure staff and patients are protected from avoidable harm.
- The trust should ensure staff understand their part in responding to a major incident in their area
- The trust should ensure agency staff competencies are monitored or assessed to ensure they were safe to work on the wards
- The trust should consider introducing competency frameworks for nursing staff working in surgical specialisms to ensure they had the right skills.
- The trust should ensure wider learning from complaints is promoted as staff did not get to hear about complaints in other areas.
- The trust should consider using the maternity specific safety thermometer to measure compliance with safe quality care.

## Action the hospital SHOULD take to improve

- The trust should ensure all staff received an annual appraisal.
- The trust should ensure handwashing facilities are available in the emergency department's corridor, to prevent patients; dignity being compromised when staff use hand basins in nearby cubicles.
  - The trust should review the exterior lighting and signage at ED to ensure members of the public are directed to the correct entrance.
  - The trust must ensure access to the emergency department children's waiting area is controlled.
  - The trust should provide signage on the store room door containing portable Entonox to inform people that compressed gases are stored there.
  - The trust should ensure access to Woman's notes when women arrive at the MLU in labour so that staff have relevant information about the woman.
  - The trust should ensure dying patients and their families and asked about their preferred place of death and that their wishes are recorded.
  - The trust should ensure risks in relation to EoLC are recorded on the risk register.
  - The trust should ensure any changes to medications are signed for appropriately.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

**How the regulation was not being met:** When a person who used services lacked capacity to make an informed decision, staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulation 11 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Need for Consent.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**How the regulation was not being met:** How the regulation was not being met: Staff did not always assess the risks of people in good time and in response to people's changing needs.

Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

**How the regulation was not being met:** Learning from incidents was not always shared and promoted within and between service specialties and across the trust to minimise the likelihood of reoccurrence.

Regulation 12 (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

**How the regulation was not being met:** Medicines were not always managed safely and in line with current legislation and guidance

This section is primarily information for the provider

## Requirement notices

Regulation 12 (2) (g) HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

**How the regulation was not being met:** People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

Regulation 15 (1) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

### Regulated activity

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**How the regulation was not being met:** There was not always sufficient numbers of suitable staff deployed to meet the care and treatment needs of patients.

Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

**How the regulation was not being met:** Staff did not all receive statutory and mandatory training to ensure they were safe and competent to carry out their role.

Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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

This section is primarily information for the provider

## Enforcement actions (s.29A Warning notice)

### Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

Start here...

Where these improvements need to happen

Start here....