Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust

Royal Shrewsbury Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Surgery	Requires improvement
Maternity and gynaecology	Good
End of life care	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.

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

This was a focused inspection, following up our inspection that took place in October 2014. At that time the hospital was rated as requires improvement overall, with caring as good.

We rated Royal Shrewsbury Hospital as requires improvement overall.

- 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.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015.
- Insufficient numbers of consultants and middle grade doctors were available.
- Nursing staff vacancies were affecting continuity of care and an acuity tool was not used to assess staffing requirements.
- The triage process for patients brought in by ambulance was inconsistent and unstructured.
- 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.
- Inconsistencies were identified in the 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.

Summary of findings

- 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
- 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 a 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.

We saw several areas of outstanding practice including:

- The trust had rolled out the Swan scheme across the trust that 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 care 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 coachingteams and facilitating continuous improvement.

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

Importantly, the trust must:

- 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 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.
- 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

In addition the trust should:

- The trust should ensure all staff received an annual appraisal.

Summary of findings

- The trust should consider using the maternity specific safety thermometer to measure compliance with safe quality care.
- 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.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The 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. Insufficient numbers of consultants and middle grade doctors were available. Existing staff had to work additional hours to cover shortfalls in the rota. The triage process for patients brought in by ambulance was inconsistent and unstructured, and patients were not always triaged face-to-face by a member of clinical staff. Access from the waiting room to treatment areas in the main department was not controlled. However, incident reporting was embedded among all staff, and feedback was given when requested or deemed necessary. In every interaction we saw between nurses, doctors and patients, the patients were treated with dignity and respect. Controlled drugs were stored in line with legislation and best practice guidelines. Safeguarding training levels were good, and staff demonstrated a thorough understanding of the safeguarding process. Treatment was planned and delivered in line with national guidelines and best practice recommendations. Staff spoke very positively about the department's managers, and told us they were supportive and approachable.
Medical care (including older people's care)	Good 	Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. Infection control systems and processes were adhered to by all staff and hygiene standards were routinely monitored. Staff planned and delivered patient's care and treatment in line with current evidence-based guidance, standards, best practice and legislation.

Summary of findings

Local and national audits of clinical outcomes were undertaken and quality improvements projects were implemented in order to continually improve patient care and outcomes.
Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.
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.
However, attendance levels for mandatory training were noted to be low in most areas in medicine and compliance with the trust target for completion of staff appraisals was below the trust target.
Ward staff were being supported on most shifts by agency and bank staff. There were insufficient consultant capacity (including vacant funded posts) in acute medicine.

Surgery **Requires improvement**

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
Infection control systems and processes were adhered to by all staff and hygiene standards were routinely monitored.
Staff planned and delivered patient's care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
Local and national audits of clinical outcomes were undertaken and quality improvements projects were implemented in order to continually improve patient care and outcomes.
Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.
It was easy for people to complain or raise a concern and they were treated compassionately when they did so.

Summary of findings

There was clear statement of vision and values, driven by quality and safety. Leaders at every level prioritised safe, high quality, compassionate care. However, attendance levels for mandatory training were noted to be low in most areas in medicine and compliance with the trust target for completion of staff appraisals was below the trust target.
Ward staff were being supported on most shifts by agency and bank staff. There were insufficient consultant capacity (including vacant funded posts) in acute medicine.

Maternity and gynaecology

Good

Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate. The service was responsive to the requirements of women from the booking-in clinic and at all stages of their journey. There was a range of choices for women during labour. Women told us they felt involved with decisions in their care.
We saw that staff followed good practice with infection prevention and control. Staff were aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the service. Staff had access to and followed policies and procedures that were based on national guidance.
We saw a positive culture within the MLU with strong leadership.
Effective systems of communication were established between the consultant led unit and the MLU, ensuring that effective care and treatment could be delivered.
A full review of the maternity service was ongoing, looking at different ways to improve the service; staff were clear about their role and levels of accountability.
However, **t**he maternity specific safety thermometer was not being used to measure compliance with safe quality care. Staff completion of some topics included in the mandatory training programme was lower than the trust target of 100%. There was no signage on the store room door containing portable Entonox to inform people that compressed gases were stored there. Woman's notes were not always available when women arrived at the MLU in labour.

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End of life care

Requires improvement

End of life care (EoLC) patients were not always asked where they wanted to be cared for in their last days. There was no specific data on how many people had died in their preferred location or how quick discharge took place for end of life care patients. Not all risks evident in EoLC were recorded on the trusts risk register. Staff were highly motivated and passionate in providing EoLC and that there was a drive for change and improvement of EoLC services at the hospital. There was evidence of good working relationships across all areas of EoLC and staff felt supported by their immediate managers.

Mortuary staff decontaminated surgical instruments manually; this exposed staff to unnecessary risk and did not provide a high level of disinfection. Infection prevention training was not part of mandatory training for mortuary staff and there were no arrangements for the regular deep cleaning of the mortuary environment.

Mental capacity documentation had not been always completed for defined ceiling of treatment decisions when a person had been deemed as lacking capacity.

Staff from the palliative care and EoLC team were not up to date with mandatory training.

However,

The trust had made EoLC one of its priorities in 2015/2016. Staff at all levels and from all departments understood the importance of a dignified death. There was evidence that learning around EoLC was being shared with staff within the trust.

The trust had rolled out the Swan scheme across the hospital, providing resources for staff and practical measures for patients and families that included Swan boxes, bags and end of life information files for staff. A new bereavement suite and three Swan Rooms for EoLC patients were also part of the scheme at the Royal Shrewsbury Hospital. The mortuary department recently had a major refurbishment and was fit for purpose.

Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. The trust took part in

Summary of findings

the national end of life care audit. The trust had taken a number of actions in response to the audit. Staff from the palliative care team attended regular multidisciplinary team meetings in specialist areas. The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an EoLC patient.

Royal Shrewsbury Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; End of life care

Detailed findings

Contents

Background to Royal Shrewsbury Hospital

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

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

The trust has a relatively new executive team. The 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).

Shrewsbury and Telford Hospital NHS Trust has been inspected 12 times since its registration with the CQC in April 2010. Royal Shrewsbury Hospital 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.

Detailed findings

How we carried out this inspection

The inspection took place 12 – 15 December 2016. It was carried out as a focused, short notice inspection, following up our inspection that took place in October 2014 and concentrating on the following five core services:

- Urgent & emergency services
- Medical care (including older people's care)
- Maternity and gynaecology
- End of life care.

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.

Facts and data about Royal Shrewsbury Hospital

The annual turnover (total income) for the trust was £326 million in 2015/16. The trust deficit was £14.6 million for the same period.

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

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%).

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	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
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

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

This was a focused inspection, following up our inspection that took place in October 2014, at which time urgent and emergency care services were rated as 'requires improvement' in the domains 'safe', 'effective' and 'responsive' and 'good' in the domains 'caring' and 'well led'.

From 1 May to 30 November 2016, 28,502 patients attended the emergency department (ED) at RSH. Of these, 5,568 were paediatric patients.

The ED at RSH has nine 'majors' cubicles and two 'majors' treatment rooms, two paediatric cubicles, three 'minors' cubicles and a resuscitation room with four bays.

A GP-led urgent care centre, run by a different provider, was located in the same building as the emergency department and shared the same entrance and reception area. The urgent care centre was open from 8am to 8pm, seven days a week. On arrival in the department during those hours, patients were triaged and 'streamed' to either the emergency department or the urgent care centre.

Summary of findings

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.

Insufficient numbers of consultants and middle grade doctors were available. Existing staff had to work additional hours to cover shortfalls in the rota and some shifts went uncovered.

The environment could not always meet the demands on the service. The triage process for patients brought in by ambulance was inconsistent and unstructured, and patients were not always triaged face-to-face by a member of clinical staff. Access from the waiting room to treatment areas in the main department was not controlled.

However, incident reporting was embedded among all staff, and feedback was given when requested or deemed necessary.

In every interaction we saw between nurses, doctors and patients, the patients were treated with dignity and respect. Controlled drugs were stored in line with legislation and best practice guidelines.

Safeguarding training levels were good, and staff demonstrated a thorough understanding of the safeguarding process.

Treatment was planned and delivered in line with national guidelines and best practice recommendations and outcomes were comparable to other NHS trusts

Urgent and emergency services

Staff spoke very positively about the department's managers, and told us they were supportive and approachable

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement, because:

- Insufficient consultants and middle grade doctors were available. Existing staff had to work additional hours to cover shortfalls in the rota.
- The triage process for patients brought in by ambulance was inconsistent and unstructured, and patients were not always triaged face-to-face by a member of clinical staff.
- The department corridor, where nurses and ambulance staff cared for patients who were waiting for a cubicle, did not have handwashing facilities. This meant staff providing care for patients waiting in the corridor did not have ready access to handwashing facilities.
- Patients were sometimes left on trolleys or wheelchairs on the department corridor, without a nurse being present and without any means of calling for assistance.
- The layout of the two 'majors' treatment rooms did not allow patients to be monitored safely.
- The children's waiting area did not meet the standards of the Royal College of Paediatrics and Child Health's (RCPCH) 'Standards for Children and Young People in Emergency Care Settings' 2012.
- Access from the waiting room to treatment areas in the main department was not controlled, which meant people could walk into the majors, minors and children's treatment areas without having to speak with staff and gain permission.
- The temperature in the medicines store room was not monitored.

However:

- Nursing rotas were fully staffed, with no vacant positions.
- Incident reporting was embedded among all staff, investigated appropriately and feedback was given when requested or deemed necessary.
- Staff had a good awareness of the duty of candour.
- The department was visibly clean and tidy with good infection control arrangements.
- Consumable equipment was safely stored and was in date.

- Controlled drugs were stored in line with legislation and best practice guidelines.
- Safeguarding training levels were good, and staff demonstrated a thorough understanding of the safeguarding process.
- Records were well maintained.

Incidents

- The trust used an electronic incident reporting system. All the staff we spoke with told us they knew how to access the system and report incidents, and had done so. They told us they received feedback on incidents as long as they ticked the 'feedback' box on the form. Staff told us they received feedback via their NHS email address, or face-to-face, as appropriate.
- Trends identified in incident reports were discussed at monthly clinical governance meetings, and cascaded to staff by email, face-to-face or on the department's notice boards.
- From May to November 2016, ED staff reported a total of 208 incidents, averaging just under 30 per month. Reported incidents fell into 35 categories. The categories with the most reports were: intentional violence and aggression (19 incidents); security problems (19); communication problems between staff, teams or departments (16); and bed shortages (15).
- We looked at ten incident reports from three days in January 2017. Matters reported included delays in accepting patients from ambulance crews, patients found to have pressure ulcers on arrival in ED, equipment and medication issues. The detail and variety of the information indicated a positive and open reporting culture in the department.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The emergency department did not hold its own mortality and morbidity review meetings. Information from the trust's mortality and morbidity meetings was fed back to ED staff via governance and trauma outcome meetings. We saw minutes of the urgent care group's governance meetings, which included detailed discussions about patients who had died.
- Other than mortality and morbidity, managers said they were not informed about learning from incidents in ED at Princess Royal Hospital, however they told us joint clinical governance meetings were due to start between the two hospitals in February 2017.
- Staff told us they did not receive feedback on incidents that had occurred elsewhere in the trust. However, an emergency nurse practitioner told us learning from serious incidents was shared through governance and staff briefings.
- 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.
- The department manager demonstrated a good understanding of the principles of duty of candour. They told us it meant being open and honest with patients and relatives if something went wrong and caused harm to a patient, and included offering to meet face to face with those affected.
- We asked two junior doctors about duty of candour. They both had an awareness of the legislation and were able to explain the process involved, and what would trigger it: such as incidents which could result in, or appear to have resulted in, the death of the person using the service or severe harm, moderate harm, death of or prolonged psychological harm to a patient.
- We were given details of an incident in ED that had triggered duty of candour. The patient did not suffer any permanent harm, and had been given a full explanation of what had gone wrong, and an apology.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy that included risk assessments for each department. ED had been assessed as a high risk area due to the number of patients and visitors and the unpredictable nature of the conditions with which they were suffering. As a result, ED had a target of 98% compliance with IPC procedures, to minimise the risk of avoidable harm to patients, staff and visitors.
- The department corridor, where nurses and ambulance staff cared for patients who were waiting for a cubicle, did not have handwashing facilities. Washbasins were

available in nearby cubicles, however using those meant staff had to enter a room where another patient was being treated, which could affect their dignity and privacy.

- We saw medical, nursing and domestic staff using personal protective equipment such as disposable gloves and aprons when appropriate.
- Hand hygiene audits had been carried out during five months from May to November 2016. The department had scored 100% in May, June and September and 95% in November, all meeting the trust's target of 95% compliance. In August 2016, the department scored 80%, below the trust's target. No audits were carried out in July or October 2016.
- In the 'majors' and 'minors' areas of the department we saw medical and nursing staff washing their hands and using antibacterial gel before and after providing care for patients, in accordance with the World Health Organisation's 'Five Moments for Hand Hygiene' guidance.
- Treatment cubicles and communal areas in majors, minors and the resuscitation areas were visibly clean and tidy during both our announced and unannounced inspections.
- Domestic staff were visible in the department throughout our visit. We saw cubicles and communal areas being cleaned frequently, and saw domestic staff using appropriate personal protective equipment while carrying out their duties.
- Domestic staff worked in the department 12 hours a day, seven days a week. Outside those hours, a team of on-call domestic staff covered the whole hospital and responded to any requests for decontamination in ED. ED staff told us the on-call team always attended promptly when they were called.
- We saw comprehensive cleaning records, which evidenced thorough daily cleaning of clinical, public and staff areas and equipment in ED.
- A senior housekeeper told us every cubicle in ED was 'deep cleaned' weekly, as well as daily cleans or those needed after cubicles had become contaminated. We saw records confirming the deep cleans were carried out as scheduled.
- The department's housekeeper told us they ensured the plastic toys from the children's waiting area were cleaned daily.
- We were given a copy of the report on the hospital's infection prevention and control nurse's 'quality and safety ward walks', carried out in ED in July, August, October and December 2016. The department had scored 86% overall in the December audit, losing marks for cleanliness of some equipment. This was a marked improvement on the preceding audits that scored 50%, 64% and 46% respectively, but was still below the trust's 98% target for its emergency departments. Actions listed for the ED manager on the December report included monitoring cleanliness and cleaning of certain items of equipment, ensuring a solution used for cleaning blood spills was available for staff and to continue to monitor and challenge 'bare below the elbows' and hand hygiene practice.
- From May to November 2016, the cleaning audit for ED and the plaster room had averaged a score of 94.4%, against a trust target of 98%.
- From January to December 2016, only one instance of MRSA had been recorded in ED, in August 2016. No instances of C. difficile or MSSA had been recorded during the same period.

Environment and equipment

- When all the cubicles in ED were full, patients arriving by ambulance waited on hospital trolleys in a corridor until space became available. While patients were not routinely left unattended in the corridor and were looked after by either ambulance staff or a nurse, we saw occasions when patients were on the corridor without any clinical staff present. There were no call bells on the corridor, so patients were not able to summon assistance if they needed it. The corridor was not fitted with oxygen or emergency equipment, and we saw ambulance staff using equipment they had brought from their ambulances to monitor patients.
- There were two treatment rooms off the ED corridor, which were not visible from the main department. One nurse was assigned to the two rooms, and also looked after patients waiting in the corridor. Because of the layout of the rooms and the corridor, if the nurse was in one of the treatment rooms they could not see or hear what was happening in the other, or in the corridor. A manager told us only low-risk patients who were not suffering from any form of confusion were supposed to be allocated to the treatment rooms because of their isolation from the rest of the department.
- During our inspection, while we were in the corridor, an elderly patient in a state of partial undress came out of one of the treatment rooms, carrying a bag of

intravenous fluid that was still attached to a cannula inserted in their arm. They walked towards the ambulance entrance door, which operates automatically to allow exit but needs a digital code to be opened from the outside, which meant the patient would not have been able to get back in had they gone outside. Our inspector intercepted the patient before they reached the door, as the nurse assigned to the area was in the other treatment room and unable to see what was happening and there were no other hospital staff present in the corridor. The patient appeared to be confused, and asked for directions to the toilet. Our inspector escorted them back into the treatment room and informed the nurse working in that area, who addressed the patient's immediate needs. We raised the incident with the nurse in charge, and shortly afterwards the patient was moved to a cubicle in the main department.

- The Royal College of Paediatrics and Child Health's (RCPCH) 'Standards for Children and Young People in Emergency Care Settings' 2012 states children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. The document also states children's areas should be monitored securely and zoned off, to protect children from harm, and access should be controlled. The children's waiting area at Royal Shrewsbury Hospital partially complied with these standards. Children could not see or hear adults who were in the main waiting area, the children's waiting area was partitioned off from the rest of the department by a low, brightly-coloured fence and gate and the area was covered by CCTV that was monitored from the hospital's security office. However, access to the area was not controlled and patients in a nearby clinic waiting area would be able to walk in if they chose to.
- Access to the main department from the public waiting area was not controlled during our inspection. A set of double doors adjacent to the reception office, which could be secured closed with electromagnetic locks, were left open allowing unimpeded access from the waiting area into the majors, minors and paediatric treatment areas. A second set of double doors gave access to the ambulance corridor and resuscitation area. During our announced inspection, staff told us the double doors adjacent to reception were kept closed and locked after 9pm to restrict public access. However, on our unannounced follow-up inspection, we were in the department until after 9pm, and the doors were left open. On that occasion, staff told us the doors were always left open.
- The exterior of the department was not well lit and signs directing members of the public to the reception area were not clearly visible.
- We inspected a random selection of 25 consumable items in the department's storeroom, and found they were all in date and in sterile packaging.
- We inspected treatment trolleys and store cupboards in the minors treatment area. We found both were stocked with an appropriate range of equipment for treating minor injuries and illnesses. We checked 20 items at random, on trolleys and in cupboards, and found they were all in sealed, sterile packaging and within their expiry dates.
- The trust's electro-biomedical engineering (EBME) department managed equipment servicing and repairs. Managers told us EBME held electronic records of equipment servicing dates and equipment was always collected from the department before service dates expired.
- We saw sufficient monitoring and assessment equipment, such as electrocardiogram machines, blood pressure and oxygen saturation monitors, blood glucose meters and tympanic thermometers were available in the department. This meant nurses did not have to wait or look for equipment when patients needed to be assessed, and patients were not kept waiting unnecessarily.
- We looked at equipment and checklists on the department's resuscitation trolley. All of the equipment was in working order and within its service date, and consumable items were stored properly and in date. The checklist evidenced regular, daily checks of the equipment.

Medicines

- Medicines, including prescription-only, pharmacy and general sales list products, were stored in locked cabinets in a room directly opposite and visible from the nurses' station. Access to the medicines storeroom was controlled by a digital lock. The nurse in charge held the keys to the medicine cabinets and issued them to authorised staff when needed. We looked at a selection

of 20 medicines and found them all to be in date and stored in sterile, tamper-evident packaging. The storeroom was air-conditioned and cool, but staff did not monitor the temperature of the room.

- Controlled drugs, which require special storage arrangements and documentation, were kept secure in a safe in the medicines storeroom. The nurse in charge controlled access to the safe keys.
- Medicines requiring refrigeration were kept in a locked refrigerator in the medicines storeroom. We saw records confirming staff checked the refrigerator temperature twice daily. Staff we spoke with were able to explain the action they would take if they found temperatures outside the permitted range.
- Technicians from the hospital pharmacy visited the department to carry out medicine stock checks three times each week. This meant the department had sufficient quantities of commonly-used medicines available at all times, and stock was removed before it went out of date.
- If medicines that were not kept in ED's storeroom were required urgently, or if the department ran out of any medicines out of hours, an on-call pharmacist was available 24 hours a day, seven days a week.
- We saw records evidencing staff completed regular checks of the temperature of the department's blood refrigerator.
- The department's emergency nurse practitioners (ENPs) were qualified as non-medical prescribers, which meant patients could be prescribed some commonly-needed medicines without having to see a doctor.

Records

- Staff used paper records while patients were being treated in ED. If patients were admitted to the hospital, their paper notes were taken to the receiving ward or unit with them. When patients were discharged from ED, their notes were kept in the reception office for up to two weeks until reception staff inputted them onto the hospital's electronic records system. Once input, the paper records were taken for secure shredding.
- Staff used a 'smart' LCD screen to monitor patients in ED at Royal Shrewsbury and Princess Royal Hospitals. This allowed department co-ordinators and managers to have an overview of the two departments, and to track patients and their clinical conditions. Every member of staff was able to update the board, and every entry was confirmed with a PIN number unique to the staff member.
- Reception staff downloaded patient records from the local ambulance service's portable electronic report system. The downloaded records were stored on the hospital's electronic system and could be printed out if hard copies were required.
- Staff used electronic handsets to record patients' clinical observations. This meant observations were recorded safely and securely at the patient's side, and allowed the nurse in charge of the department to have an overview of all patients via a summary screen. However, the handsets could not communicate with the department's 'smart' screen and staff had to transfer observations manually to the screen and to the department's paper records.
- All staff had name and grade stamps, which we saw them use when they made entries on patients' paper records. This ensured details of the person making the entry were legible, and protected staff from entries being made in their name without their knowledge.
- We looked at 14 sets of patient records. We did this to ensure that what patients and staff had told us was reflected in the records. We found they were properly completed and included timed and dated details of patients' observations, fluid and food intake, 'SBAR' (situation, background, assessment and recommendation) handover records. Staff had used their personal issue name and grade stamps against each entry the made.

Safeguarding

- We saw training records which showed all doctors, nurses and healthcare assistants working in ED were trained to level 2 safeguarding children and vulnerable adults as part of their trust induction. All of the staff we spoke with were familiar with the trust's safeguarding process, and several told us they had made safeguarding referrals.
- We saw training records which showed 64% of doctors, 77% of nurses and 88% of healthcare assistants in ED were trained to level 3 safeguarding children. The department manager told us they planned to have all of their nurses and healthcare assistants trained to this level by February 2017, and showed us a training plan to confirm that. New staff were allowed six months to

complete their training. All of the staff who had not completed level 3 training, apart from one doctor, were in their first six months in the department, and the training plan met the six month deadline.

- Staff told us they had frequent training, delivered by the trust's safeguarding lead, on recognising and reporting possible non-accidental injuries to children. We saw paediatric patient notes forms included a safeguarding checklist, and saw three sets of completed notes, in all of which the checklist had been completed.
- We saw examples of four safeguarding referrals staff had made about vulnerable children. All had been processed effectively and contained comprehensive details of the concerns.
- Staff had access to a 'safeguarding box', which was kept at the nurses' station. The box contained safeguarding referral forms and instructions on how to complete them and what additional actions to take, contact details for the hospital's safeguarding lead and safeguarding support nurse, and contact details for local authority safeguarding departments and out-of-hours emergency duty teams.
- The safeguarding box also contained a copy of the trust's adult and child protection policies, guidance about how to report suspected domestic violence or abuse and information about modern slavery.
- Staff who had completed their safeguarding training day demonstrated a good level of knowledge about safeguarding adults and children, modern slavery and female genital mutilation.

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%.
- Nurses' training included food safety, infection prevention and control, cardiopulmonary resuscitation, moving and handling, blood transfusion and fire safety awareness. We were given records showing 79% of ED's nurses had completed their mandatory training.
- Doctors' training comprised moving and handling, infection control and handwashing, dementia awareness, fire safety, resuscitation, medicines management and blood transfusion. Records showed 55% of ED's doctors had completed their training.

Assessing and responding to patient risk

- There was an inconsistent, unstructured triage and assessment process for patients brought into the department by ambulance. The department did not have a policy or standard operating procedure for assessing patients brought in by ambulance. On arrival, one member of the ambulance crew waited on the department corridor with their patient while the other spoke with the nurse in charge and gave a verbal handover. If there was space in the department the ambulance crew then brought their patient in and transferred them to a hospital trolley. However, if the department was full, the ambulance crew were asked to wait on the corridor with their patient. We observed several instances when this happened without a member of hospital staff seeing or assessing the patient, and saw patients who had waited on the corridor be transferred to hospital trolleys in ED cubicles without having had any contact with hospital staff.
- From October to December 2016, 35% of ambulance handovers took longer than the national target of 30 minutes. Of these, 23% were over an hour and 77% were between 30 minutes and an hour. This meant patients were waiting on ambulance trolleys longer than national guidance said they should be, and prevented ambulances becoming available to respond to further emergency calls.
- 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.
- No patients had waited in ED longer than 12 hours following a decision to admit, however 10% had waited between four and 12 hours following a decision to admit. This was significantly worse than the England average of 3%.
- From October to December 2016, the department reported 341 'black breaches'. Black breaches occur when the time from ambulance arrival to the patient being handed over to ED staff took longer than 60 minutes. Monthly totals varied between a low of 93 in December 2016 and a high of 126 in October 2016.

Urgent and emergency services

- Royal Shrewsbury Hospital's emergency department is part of the West Midlands regional trauma network, and is designated as a 'trauma unit'. This means they are able to deal with all but the most seriously injured patients, and are able to stabilise those patients requiring onward transfer to a major trauma centre. We spoke with one band 7 and three band 6 nurses, all of whom were familiar with the trauma network's procedures and could explain how they would arrange a hyper acute transfer to a major trauma centre if one of their patients required it.
- Staff used the National Early Warning Score (NEWS) system to monitor deteriorating patients and trigger appropriate referrals to senior staff. If a patient's NEWS score was six or higher, the electronic observation recording system instructed the user to consider a call to the hospital's critical care outreach team (CCOT). We were shown a copy of the trust's 'NEWS parameters and escalation categories' policy which provided instructions on calculating NEWS and reiterated the need to escalate patients scoring four or five to the nurse in charge, and six or higher to the CCOT and doctors.
- On their arrival in the department, staff carried out a 'Waterlow' assessment on all patients with reduced mobility. The Waterlow scale is a nationally-recognised tool to gauge patients' risk of suffering pressure ulcers.
- We saw a copy of the hospital's structured escalation plan to respond to pressure on the emergency department. It worked on three levels of pressure; colour coded as green, yellow and red, and provided details of events which would trigger each level and actions to be taken at each stage. At the time of our inspection, the department had been experiencing significant pressure for some time, and all of the escalation actions had been implemented.
- One consultant told us the escalation plan did not provide any practical assistance to ED, as they had been at a high level of escalation for so long it had become normalised. They said they were very well supported by staff in the department and middle managers, but they felt that at trust level no action was taken to help them.
- Nurses provided a 'streaming' service at the reception desk. They carried out a brief assessment of patients who had self-presented, to direct them to the emergency department or the urgent care centre as appropriate. We were shown a copy of the 'streaming protocol' document used in this process, which used a simple, four-stage flow chart to establish where patients needed to be seen, and included space for the patient's details and the rationale for the streaming decision. Once completed, the form was retained as part of the patient's records. We observed nurses carrying out streaming and saw the system worked effectively and ensured patients were sent to the most appropriate pathway for their condition.
- The trust's designated emergency department for children was at Princess Royal Hospital; however facilities were available at Royal Shrewsbury Hospital to provide treatment for children with minor ailments or injuries. A paediatric 'crash' team was available 24 hours a day, seven days a week for emergencies involving children. The crash team would start emergency treatment to stabilise the child before they were transferred to Princess Royal Hospital under emergency conditions.
- We asked the trust for data on the number of patients screened and receiving antibiotics for sepsis within an hour of arrival at the department, to assess their performance against the NHS national CQUIN indicator for timely identification and treatment. We were provided with trust-wide data which showed that for quarter 3 2015/2016 (October – December 2016) the trust achieved 56.8% for eligible patients screened for sepsis and 36.4% eligible patients receiving antibiotics. The trust told us the target for both indicators was 50% in quarter 3.
- The department manager showed us records which evidenced all band 6 nurses working in the ED were qualified in emergency paediatric life support (EPLS). This meant there was always at least one EPLS-qualified nurse on duty.
- We were shown records which evidenced 80% of the staff in ED had a current paediatric basic life support (PBLS) qualification. Apart from a small number of staff who were new starters or off on maternity leave, all staff who did not have a current PBLS qualification were shown to be booked on paediatric intermediate life support courses.
- Adult basic life support was included in mandatory training for nurses and healthcare assistants. The hospital's resuscitation services team provided adult in-hospital resuscitation training as part of the statutory safety update day for doctors working in ED.

Nursing staffing

- Due to the varied nature of demand in different hospitals, there is no national tool to assess nursing staff requirements in emergency departments. Managers assessed staffing requirements based on expected local peaks and troughs in demand and historic data. The department was staffed by one band 6 nurse, eight band 5 nurses and two healthcare assistants on days, and one band 6 nurse, six band 5 nurses and one healthcare assistant on nights. An extra healthcare assistant worked nights on weekends. One qualified nurse worked on 'streaming' at the reception desk, one worked in the resuscitation area, leaving six registered nurses working in majors during days, and four overnight. During our inspection we saw nursing staff were constantly busy and under pressure, but ensured patients' requests and call bells were always answered promptly.
- Apart from June 2016, from May to October 2016, all nurse and healthcare assistant shifts in ED were covered. In June 2016, 98% of rostered shifts were covered. However, to achieve this level of cover the department had used eight times as many bank and agency nurses as had been planned and budgeted for. The department budget included 3% bank staff and no agency use, however on average 13% bank staff and 13% agency staff had been used to ensure sufficient nurses and healthcare assistants were on duty. However, until mid-August 2016, ED staffing had included the clinical decisions unit (CDU). In mid-August CDU staffing had moved to another budget. In September and October 2016, bank and agency staff use in ED, while still over five times the budgeted figure, had reduced to 10% and 8% respectively.
- From May to October 2016, the department had vacancies for nurses and healthcare assistants. Vacancy numbers peaked at 16.8 whole time equivalent (WTE) in July 2016 and reduced each month to 4.6 WTE in October 2016. At the time of our inspection in December 2016, the department did not have any vacant nurse or healthcare positions.
- During times of anticipated increased pressure and demand, the department used an extra nurse from an agency, referred to as an 'escalation nurse'. The nurse was used to look after patients waiting on trolleys on the ED corridor and in two treatment rooms off the corridor, and to cover breaks in the main department. We saw records showing escalation nurses of various grades were requested on 27 occasions between May and November 2016. On two occasions, the post could not be covered by bank or agency staff and was left vacant.
- The department had two registered children's nurses. When neither children's nurse was on duty, staff could contact the hospital's children's assessment unit for advice and support if sick or injured children needed to be treated. The children's assessment unit was open 24 hours a day, seven days a week. This met the guidance of the RCPCH 'Standards for Children and Young People in Emergency Care Settings' 2012.
- Emergency nurse practitioners (ENPs) were present in the department between 11am and 10.30pm, seven days a week. An ENP is a nurse who has been specially trained to treat minor injuries. ENPs are qualified to assess, diagnose, treat and discharge patients with certain injuries without having to refer to a doctor.
- We observed a handover between day and night nursing teams, which took place in two stages. First, the off-going nurse in charge met with the oncoming team in a staff room, and provided them with an overview of ED including patient numbers, any new procedures or practices, bed availability in the hospital and cubicle space in the department. Following this, the nurses in charge carried out a patient-by-patient handover at the electronic whiteboard. This ensured the nurse in charge at the start of their shift had a good understanding of the condition of all the patients in ED.
- We saw copies of fortnightly sickness reports sent to the directorate matron by ED's ward manager. The reports gave details of staff on long- and short-term sickness, with expected return dates, occupational health referrals and arrangements such as alternative duties to help staff return to work. This allowed the matron to have an overview of the department's staffing needs.

Medical staffing

- The Royal College of Emergency Medicine suggests that 16 consultants were needed to run a safe effective emergency department of this size. The department had 2.4 whole-time equivalent consultants, which was not sufficient to provide 16 hours of consultant presence each day. The hospital's consultants were in ED from 8.30am to 8pm, Monday to Friday. The trust's consultants working extra shifts, and locum consultants, made up the shortfall.

- Four consultants, from both Royal Shrewsbury and Princess Royal hospitals provided on-call cover overnight and at weekends. The shortage of consultants working in the department meant each had to provide additional on-call cover, working between one night in four and one night in five. Two consultants told us they felt this situation compounded the recruitment difficulties faced by the hospital, as prospective consultants were put off by the amount of on-call duty they would have to provide.
- We were given records of consultant cover from June 2016 to January 2017. A total of six consultants provided on-call cover for ED during the 214 days in this date range. Three of the consultants covered 66% of the days between them, with one consultant alone covering 29%, almost one day in three.
- Two consultants told us they were supposed to attend the hospital 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 onerous and unsustainable.
- A doctor told us the hospital was finding it difficult to recruit consultants to work in the emergency department. They said they believed this was because of misconceptions that the hospital was remote from urban areas where doctors had the choice of several hospitals, close together, and an incorrect belief that the hospital was small, and was not using 'cutting edge' procedures.
- Outside the hours when consultants were present in the department, medical cover was provided by middle-grade doctors, supported by an on-call consultant from either Royal Shrewsbury Hospital or Princess Royal Hospital. If required because of patient numbers or acuity, the on-call consultant returned to the department.
- However, the department was also short of middle grade doctors 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.
- From June to November 2016, consultants covered middle grade doctor shifts in ED on 15 occasions. On a further 10 occasions, middle grade shifts were covered by junior doctors and 29 middle grade shifts could not be covered at all.
- A resident paediatrician, advanced paediatric nurse practitioner, associate specialist or paediatric consultant was on site at the hospital from 9am to 10pm Monday to Friday, and noon to 10pm on weekends. They held a paediatric bleep and were available to provide advice and assessment for children who attended ED. Outside those hours, a non-resident paediatric consultant was available on-call.

Major incident awareness and training

- We saw copies of the trust's major incident and business continuity plans were kept in a clear plastic document tray attached to the wall of the band 6 nurses' office. All the staff we spoke with were aware the plans were kept there. There were at least two staff who had access to the office on duty at all times.
- We also saw ED's plans for dealing with a loss of their supply of piped oxygen, a loss of piped suction, structural damage from adverse weather and unavailability of an ambulance service. The plans contained clear, concise instructions on what action to take in the event of any of these incidents, to protect patients from avoidable harm.
- The ED manager told us major incident training and awareness was included in the department's programme of study days. We were shown records evidencing 54% of ED staff had completed major incident and hazardous material decontamination training, which ensured a sufficient number of trained staff were on duty at all times. Apart from two staff who were on long term absence from the department, all of the remaining staff were booked to undertake the training on the next study day, in Spring 2017.
- We were shown a copy of the plan for a major incident table top exercise held in November 2016. We also saw an attendance record showing several senior staff from ED had taken part in the exercise.
- ED had a lockdown procedure to keep patients and staff safe in the event of a security threat. Staff practiced the procedure as part of the department's study days. We

were shown a copy of the lockdown procedure which contained simple, clear instructions about how to secure the department, including a plan showing the location of doors which needed to be secured.
- Major incident and decontamination equipment was stored securely in an building at the front of the emergency department. An area between the equipment store and the ambulance entrance to ED was designated as the site where staff would set up the hospital's decontamination tent. The major incident and decontamination equipment was audited annually. The audit was completed by the trust's emergency planning manager and an emergency planning manager from an NHS ambulance service. Data on the hospital's compliance with NHS emergency planning, resilience and response core standards was submitted to NHS England and the local clinical commissioning group annually. This provided reassurance of the hospital's ability to respond to a major incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Treatment was planned and delivered in line with national guidelines and best practice recommendations.
- Pain scores were assessed and, when needed, pain relief administered promptly.
- Patients were offered hot food at mealtimes, and hot and cold drinks at regular intervals. Nurses had access to cold food for patients outside mealtimes.
- Induction and training for new and locum staff was comprehensive and structured.
- Multidisciplinary team working was embedded, both within Royal Shrewsbury Hospital and with specialist services at Princess Royal Hospital.
- The trust was not an outlier for any clinical procedures carried out in its two emergency departments.
- The trust's emergency departments, across both hospitals, were contributing to the Royal College of Emergency Medicine's consultant self-audit programme and audits on treatment of moderate and acute severe asthma and severe sepsis or septic shock.

However:

- Understanding of the Mental Capacity Act 2005 amongst staff we spoke with was not consistent.
- The patient outcomes from audits showed mixed results.

Evidence-based care and treatment

- We were shown care pathway documents, based on the Royal College of Emergency Medicine's clinical guidance, National Institute for Health and Care Excellence and the 'Clinical Standards for Emergency Departments' guidelines, and best practice. The documents included the 'sepsis six' pathway which assisted staff to identify and provide appropriate treatment for patients presenting with severe sepsis or septic shock symptoms, and a fractured neck of femur pathway.
- Patients suffering from a suspected stroke were normally conveyed direct to Princess Royal Hospital (PRH), which was the trust's stroke centre. RSH ED had a procedure in place for a rapid transfer to PRH if patients self-presented at RSH with stroke symptoms, or began to develop them while in the department. A service level agreement was in place with an ambulance service to provide high-dependency crews to facilitate such transfers.

Pain relief

- The trust's pain management policy incorporated the Faculty of Pain Medicine's 'Core Standards for Pain Management (2015)'.
- All registered nurses in the department were able to administer paracetamol under a patient group direction (PGD). A PGD is a written instruction, put together by a multidisciplinary group including a doctor, pharmacist and, in this case, a nurse. It allows nominated healthcare professionals to supply or administer medicines to patients in specified circumstances. The existence of this PGD meant patients experiencing mild to moderate pain did not have to wait to see a doctor before they received pain relief.

- We saw pain scores recorded in patients' notes, documenting their pain levels on arrival in the department and at regular intervals after being given pain relief medicine.
- Patients we spoke with who had experienced pain told us staff assessed their pain and provided them with pain relief quickly when they needed it.
- The trust's two emergency departments were not reported separately in the CQC's 'ED Survey' 2014. Overall, the trust scored 4.93 out of 10 for the question "how many minutes after you requested pain relief medication did it take before you got it?", which was similar to other NHS trusts across England. The trust scored 7.49 out of 10 for the question "do you think the hospital staff did everything they could to help control your pain?". This was also about the same as than other NHS trusts in England.

Nutrition and hydration

- We saw patients who were in ED, waiting to be admitted to the hospital, being provided with a choice of cereals and toast for breakfast and hot meals at lunch and dinner. A sister told us the ED housekeeper took order for hot meals twice daily and they were provided by the hospital's catering department.
- Staff had access to a stock of snack boxes, sandwiches and pasta pots if patients needed a meal outside normal mealtimes.
- Patients we spoke with told us they had been offered snacks and drinks and, where appropriate, hot meals while they were in the department.
- We saw patients being offered and provided with a choice of hot and cold drinks. Staff told us they could make drinks whenever patients needed them, and the housekeeper carried out a drinks round of the whole department twice a day, once in the morning and once in the afternoon. We spoke with the housekeeper, who told us they asked the nurse in charge which patients were allowed to drink before starting the drinks round, so they did not inadvertently offer drinks to patients who were 'nil by mouth' or unable to take fluids orally.
- Part of ED's business continuity plan dealt with a loss of catering services at the hospital, and detailed action staff should take to ensure they were still able to offer food and drinks to patients.

Patient outcomes

- As a trauma unit and part of the West Midlands regional trauma network, the hospital contributed patient outcome data to the national Trauma Audit and Research Network (TARN). The results of the 2015/16 TARN audit showed there were 1.4 additional deaths, compared to other trauma units and major trauma centres, out of every 100 trauma patients treated at the hospital. This was better than the 2014/15 results which recorded 2.0 additional deaths out of every 100 trauma patients treated at the hospital.
- We were given copies of three TARN peer review visit reports, from visits carried out in September 2016, two of which related to ED and one to rehabilitation services. In the two reports relevant to ED, 'definitive care measures' and 'reception and resuscitation measures', the department scored 73% and 77% respectively. The reports highlighted areas of good practice such as the hospital's well-established and engaged trauma group who met regularly to share learning, recent improvement in the quality and completeness of the hospital's TARN data submissions, the quality of the hospital's trauma guidelines and documentation and the availability of ED consultants out of hours. The reports did not identify any immediate risks or serious concerns relating to ED. TARN do not set benchmarks for their peer reviews. The contents of their reports are shared with each provider to allow them to identify areas where improvements can be made.
- The department manager told they gave feedback to individual staff when areas for improvement were identified by TARN audits.
- The trust was not an outlier for any clinical procedures carried out in its two emergency departments. This means outcomes from these procedures were within NHS England's normal expectations.
- The trust's emergency departments, across both hospitals, were contributing to the Royal College of Emergency Medicine's consultant self-audit programme and audits on treatment of moderate and acute severe asthma and severe sepsis or septic shock.
- In the most recent Royal College of Emergency Medicine (RCEM) audit from 2013 for consultant sign-off, RSH performed worse than the England average for one of the four measures and comparable to the average for three of the four measures. The measure for which the hospital performed worse was: ST4 (a qualified doctor in their fourth year of specialist training) or more senior doctor saw the patient (38%)

- In the 2013/14 RCEM audit for asthma in children, RSH performed better than the England average for six of the ten measures, and worse than the average for two of the ten measures. The measures for which the hospital performed better were: assessment of respiratory rate (81%), oxygen saturation (81%), pulse (81%), Glasgow Coma Scale score (77%), temperature (77%) and peak flow (a test that measures how fast a patient can breathe out) (19%). The measures for which the hospital performed worse were: treatment with intravenous hydrocortisone (42%) and provision of a discharge prescription for oral prednisolone (25%).
- In the 2013/14 RCEM audit for paracetamol overdose, RSH performed worse than the England average for three of the four measures and better than the England average for one of the four measures. The measure for which the hospital performed better was 'recommended treatment received' (91%). The measures for which the hospital performed worse were: patients whose plasma (part of their blood) level was tested earlier than four hours after ingestion (14%), the proportion of patients who received N-acetylcysteine, a medicine to treat paracetamol overdose, within one hour of arrival (0%) and staggered overdoses receiving N-acetylcysteine within one hour of arrival (0%).
- In the 2013/14 RCEM audit for severe sepsis and septic shock, RSH performed better than the England average for one of the 12 measures and worse than the England average for three of the 12 measures. The measure for which the hospital performed better was capillary blood glucose recorded within 15-20 minutes of arrival (56%). The measures for which the hospital performed worse were: high flow oxygen initiated in ED (30%), first intravenous crystalloid fluid (such as saline drips) given in ED (78%) and evidence in notes that blood cultures were obtained in ED (56%).
- In the 2014/15 RCEM audit for initial management of the fitting child, RSH performed worse than the England average for one of the five measures and comparable to the England average for two of the six measures. It was not assessed for either of the measures relating to the management of active seizures (where the child is actively fitting on arrival). This includes the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival. The measure for which the hospital performed in the lower quartile was recording an eyewitness history for all audited patients (88%).
- In the 2014/15 RCEM audit for mental health in the ED, RSH performed worse than the England average for one of the eight measures and comparable to the England average for the remaining seven measures. The department did not meet the fundamental standard of having a documented risk assessment taken or of having a dedicated assessment room for mental health patients. The measure for which the hospital performed in the lower quartile was for a provisional diagnosis being documented (2%).
- The trust did not measure its individual emergency departments' unplanned re-attendance rates separately. Overall, from August 2015 to July 2016 the trust's unplanned re-attendance rate to ED within seven days of a patient being discharged was 5.3% compared to an England average of 7.7%, but slightly higher than the national standard of 5%.

Competent staff

- The department's two emergency nurse practitioners (ENPs) and GPs from the urgent care centre provided additional training and support for nurses working on the reception desk 'streaming' service, to allow them to triage patients safely and effectively. The streaming process was also covered on an ED study day during 2016.
- On starting work in ED, all nurses completed an induction programme and a competency assessment. We were given copies of the induction pack and clinical skills checklist, both of which were comprehensive, well-structured documents and provided good evidence of staff members' training and capabilities.
- A similar induction pack was used for locum doctors. We were given a copy of the pack, which included details on services provided by the hospital, where to refer patients for other services, quality indicators, local governance, infection control procedures, management structure, and the processes for referral to diagnostic services. It also provided a list of useful telephone and extension numbers, local information including accommodation, and finished with a section for the locum doctor to sign and confirm they understood and agreed to follow the department's policies and procedures.
- A newly qualified nurse told us they had had a two-week supernumerary period when they started work in ED, and had completed their induction portfolio with help and training from other staff.

- Each of the band 6 nurses in ED acted as a link nurse for an area of specialised knowledge such as infection prevention and control, hand hygiene, diabetes, paediatrics, blood transfusions and health and safety. This meant that they could support their colleagues with advice and the latest information regarding their speciality.
- We spoke with a trainee advanced care practitioner (ACP), who had many years' experience as a nurse before taking on the ACP role. They told us their training was structured around an MSc course at a local university and the trust allowed them 15 hours per week as non-clinical time, to attend university lecturers, in-house junior doctors' training sessions and complete self-study and research. The remainder of their time was spent working in the department, under supervision from the consultants, putting their skills into practise.
- One nurse who worked in the department regularly, through the trust bank, told us they were attending a paediatric immediate life support course, despite not being a permanent member of staff.
- A healthcare assistant told us they had opportunities to attend in-house training, offered by the department's consultants and by specialist staff throughout the hospital.
- ED nurses were able to undertake training on diabetes, 'ALERT' (acute life-threatening events, recognition and treatment), fundamentals of care, stabilising the critically ill child, sepsis and a university module on assessment and management of the acutely ill adult.
- In January 2017, we were given data confirming 84% of nursing staff and 90% of medical staff in ED had had an appraisal during 2016/17. Apart from those on long-term absence, all remaining staff had an appraisal booked before the end of March 2017.

Multidisciplinary working

- On patients' arrival in the department, a nurse assessed their presenting condition and, where appropriate, referred them to a GP-led urgent care centre based in the same building. This was a seamless process for patients who only had to book in once, and used the same waiting area as patients being seen in ED.
- When staff transferred patients from ED to other wards or units in the hospital, they used a standard format, 'SBAR', (situation, background, assessment and recommendation) to structure the handover procedure and ensure no salient information was missed. Staff told us they were familiar with and used this system regularly. We saw SBAR template forms being completed prior to patients being moved out of ED. Once filled in, SBAR templates were retained in patients' notes and formed part of their records.
- Staff from the local community trust's integrated care team attended ED daily to assess any patients they could support at home and therefore for whom they could facilitate discharge.
- A senior manager told us they were well supported by the local NHS mental health trust's rapid assessment and intervention team, who looked after adults living with mental illnesses. However, they also said the arrangement for assessment of children living with mental illnesses who were under the care of services in Wales did not always run smoothly. They told us about an instance when they had referred a child in ED for assessment on a Friday afternoon, and said they were told the child and adolescent mental health service who provided services in Shrewsbury on behalf of the trust in Wales would not attend until the following Monday. The manager told us a meeting with the clinical commissioning groups concerned was scheduled for January 2017.
- We observed board rounds held in the department at 4pm each day. Consultants and middle grade doctors from every specialty in the hospital attended the meeting, and we saw a culture of open dialogue and appropriate professional challenge between specialties. The emphasis during the board round was firmly on providing the most appropriate care for patients waiting to be admitted, and on formulating plans for patients and flow throughout the evening and overnight.
- Senior staff told us they were supported by the rest of the hospital when ED was under pressure. They said they did not feel isolated, and that ED pressure was seen as a 'whole hospital' issue.
- We saw a team of doctors from the hospital's medical wards attending ED to assess and treat medical patients who were waiting to be admitted to a ward. A senior ED nurse told us this was normal practice when there were delays in the department, and it ensured assessment and treatment was not delayed because of a shortage of space on the receiving wards.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week.

- Staff had access to support from the hospital's pharmacists during pharmacy opening hours, and from an on-call pharmacist out of hours.
- Diagnostic imaging services such as x-ray and computerised tomography (CT) scans were available 24 hours a day, seven days a week.

Access to information

- Two doctors told us the trust's intranet guidelines were difficult to find and many were out of date. They told us guidelines were stored in different areas of the intranet and the search facility was not effective; this meant there were frequent occasions when the correct guidance could not be found. They gave us an example of one guideline which advised treatment with a medicine not stocked by the hospital. Doctors told us when they experienced difficulties locating guidance on the trust's intranet they would either ask a more senior doctor for advice or use recognised on-line guidance from external organisations.
- The department's 'smart' LCD screen gave staff an overview of patients in ED at Royal Shrewsbury and Princess Royal Hospitals, and allowed them to track patients and their clinical conditions.
- All nursing and medical staff had access to the trusts computer systems. Medical alerts and trust news were communicated through the intranet. Group or individual messages were circulated through personal email accounts.
- We saw there were sufficient computer terminals around the department to enable staff to access information or update files without having to queue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked five nurses about assessing patients' capacity to consent to or refuse treatment, under the Mental Capacity Act 2005. We found their understanding was not consistent. Some demonstrated a sound awareness of the principles of the Act; others had not heard of the process. We raised this with the department manager before we left the hospital. They acknowledged the issue and told us they would arrange refresher training for all the staff, early in 2017.
- Three junior doctors demonstrated a good understanding of the concept of mental capacity, and told us they would check with a senior doctor if they were in any doubt about a patient's ability to consent to or refuse treatment.
- The 'safeguarding box' held at the nurses' station contained information about the Mental Capacity Act 2005 and its 'no decision about me without me' guidance on assessing mental capacity. It also included a mental capacity assessment form which detailed the two-stage test for capacity and allowed staff to record the rationale behind the decision, including acting in the patient's best interests and using the least restrictive options.
- Information on Deprivation of Liberty Safeguards (DoLS) was also included in the safeguarding box, although staff told us they rarely had to use DoLS as patients were not in the department for long enough to need an application.

Are urgent and emergency services caring?

Good

We rated caring as good, because:

- In every interaction we saw between nurses, doctors and patients, the patients were treated with dignity and respect.
- The department's response rate and recommendation level in the NHS 'Friends and Family' test were both significantly better than the England average
- Patients we spoke with were all happy with the way in which staff cared for them
- Patients and their families were involved in decisions about their care and treatment

Compassionate care

- Throughout our inspection, we saw nurses, doctors, healthcare assistants and domestic staff treating patients, their relatives and carers with dignity and respect. We heard staff introducing themselves, in accordance with the NHS Employers' 'Hello my name is' campaign, and asking patients by which name they preferred to be called.

Urgent and emergency services

- We saw staff knocking on side room doors, and checking patients were ready for them before entering side rooms and cubicles.
- We saw a nurse and a student nurse providing personal care for an elderly patient with dementia. They carefully explained everything they were going to do and allowed the patient time to consider and respond before providing each aspect of the patient's care. They treated the patient with the utmost respect.
- Between October 2015 and November 2016, 94% of respondents to the NHS 'Friends and Family Test' patient experience survey said they were 'extremely likely' or 'likely' to recommend the department to their friends and family, which is better than the England average of 86%.
- Patients we spoke with all told us they were happy with the way staff had looked after them. They described staff as 'very caring'.

Understanding and involvement of patients and those close to them

- We spoke with 12 patients who had been seen by clinicians. All of them told us they had been involved in decisions about their care and knew what treatment was planned for them.
- One of the questions asked by the trust's inpatient survey in 2014 was whether patients felt they had received sufficient information about their condition whilst in ED. The trust scored eight out of 10 for this question, although results were not broken down between the two emergency departments.

Emotional support

- Nursing staff told us senior nurses or doctors spoke with patients or family members when unpleasant news had to be given.
- 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.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- 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. Performance averaged 81% against the England average of 89%.
- Ten per cent of patients waited between four and 12 hours following a decision to admit. This was significantly worse than the England average of 3%.
- The emergency department was no longer a suitable size to cope with the demands of rising patient numbers.
- Information leaflets were not available or obtainable in languages other than English.
- Senior managers told us a translation service was available via the hospital's switchboard, however staff in the department were not aware of the service and had never used it.

However:

- All staff were provided with a workbook-based learning disabilities training programme.
- Staff used and understood a nationally-recognised symbol to identify patients living with dementia.
- Complaint investigations were comprehensive and focused on improving services for patients.

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. The trust board recognised the existing emergency department was too small to cope with the increased number of patients and 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.
- NHS Future Fit's 17 stakeholders were considering how best to meet health needs for everyone living and working in Shropshire, Telford and Wrekin and mid Wales. As well as urgent and emergency care, the programme was working on long-term conditions and

frailty, diagnostic and treatment centres and locally-planned care services. Changes proposed included retaining services at both Princess Royal Hospital and Royal Shrewsbury Hospital as urgent care centres, and creating one new emergency centre in the county.

- Managers planned staff numbers to meet the demand of anticipated patient numbers, and staff worked hard to provide timely, high-quality care. Initiatives such as the use of 'streaming' nurses and the availability of the urgent care centre had been put in place to maximise the use of space available in the department.
- The department ran a clinic between 9am and 10.30am, Monday to Friday, for patients who had been treated in ED for soft tissue injuries and minor burns. The clinic offered facilities for wound care and re-dressing.

Meeting people's individual needs

- The department provided information leaflets about self-care following treatment for common injuries and illnesses, however they were only available in English. A senior manager told us they thought versions in other languages were available to print off, but on checking, found they were not. The manager told us they would arrange for multi-lingual leaflets to be made available for staff to print from the trust's intranet when required.
- We asked a senior manager about translation services. They told us the department used multilingual staff when possible, and staff had access to a translation service via the hospital switchboard. During our unannounced follow-up inspection, a situation arose involving two friends of a patient, none of whom spoke English. Staff on reception and security staff tried to communicate with the patient's friends for about half an hour before a doctor who spoke their language became available to translate. After the incident had been resolved, we asked the reception staff if they had access to a translation service, and they told us they did not.
- We saw a copy of the trust's learning disabilities competency workbook, and saw records showing 80% of nurses and healthcare assistants in ED had completed the training. The workbook covered the definitions of and differences between learning disabilities and learning difficulties. It explained the range of learning disabilities and gave an overview of the trust's guidelines. It also gave information about the trust's specialist learning disabilities team and how to obtain their help; discussed options for communicating with patients living with a learning disability, and explained the requirements of the Mental Capacity Act 2005 and 'best interests' decisions.
- The 'safeguarding box' held on the nurses' station included the trust's guidelines on looking after people living with learning disabilities.
- Three of the department's nurses acted as dementia link nurses and supported their colleagues with advice and training.
- Patients living with dementia were identified with a nationally recognised symbol, a butterfly, on the department's electronic whiteboard. All the staff we asked about the symbol knew its significance and told us it helped them to know which patients may need additional support.
- ED used a nationally-recognised series of posters and activity packs featuring a toy animal to reduce anxiety for children attending the department, and explain things that were happening in child-friendly terms.
- We observed an emergency nurse practitioner performing wound care for a child who was living with autism. A healthcare assistant built rapport with the patient and distracted them while the treatment took place, which helped the child remain calm and allowed the procedure to be completed quickly and without any upset.
- The children's waiting area had a good selection of toys and books, suitable for a range of ages.
- The department had two treatment cubicles designated for children, which could be accessed from the children's waiting area without going through the main department. The cubicles were being redecorated during our inspection, and were being painted with brightly-coloured designs.
- If patients were waiting to be admitted from ED for an extended period of time, staff arranged for a hospital bed to be brought into the department and patients were moved from the hospital trolley to the bed. We saw three patients who had been waiting longer than four hours after doctors had decided to admit them, who had been moved onto hospital beds.

Access and flow

- From May to November 2016, 28,502 patients had been treated in ED. Of those, 20% were children.
- The Department of Health's standard for emergency departments is that 95% of patients should be

admitted, 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.

- Due to the different specialties provided by Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital, patients who attended ED at either hospital sometimes needed to be transferred to the other to be admitted. When this happened, patients often moved from one ED to the other to wait for a bed. The trust recorded the first 'decision to admit' time regardless of a subsequent move to the second ED, which meant patients' waiting times were documented accurately.
- From August 2015 to July 2016, the number of patients who left the trust's emergency departments without being seen for treatment was better than the England average of 3.6%. The number peaked at 3.2% in March 2016 and was at its lowest, at 2%, in April 2016.
- Managers from the emergency department and the hospital's specialties held a 'capacity huddle' each morning, to assess which patients needing to be admitted from ED could be moved to a ward. ED managers told us this helped flow in ED to be seen as a 'whole hospital' issue rather than leaving them isolated. ED managers also attended the hospital's bed management meeting, which was held at 1pm, Monday to Friday.
- An LCD screen on the wall of the nurses' station displayed live information from West Midlands Ambulance Service NHS Foundation Trust's command and control system. This meant staff knew how many ambulances were on their way in to the department at any time, and allowed staff to view the condition, age and sex of patients who were being treated and conveyed by the ambulance crew. The system also allowed managers to see how long ambulances had been waiting at the department.
- Ambulance crews from the Welsh Ambulance Service NHS Trust also brought patients in to the department. While they were en route, the ambulance crew telephoned the ED on a direct line, to let staff know their estimated time of arrival and details of their patient. This meant staff were always aware of the patients who were on their way in by ambulance and could make plans to accommodate them.
- Two nurses normally worked on reception, to provide a 'streaming' and triage service for patients who self-presented at the department. The nurses had access to an assessment room if they needed to carry out physiological observations, such as blood pressure, pulse and respirations, before directing patients to the most appropriate service or area of the department. The nurses could refer patients to an urgent care centre, located in the same building and staffed by GPs from a different healthcare provider, or to the minor or major treatment areas of ED. Occasionally, only one nurse worked on the streaming desk. Nurses told us this could be inconvenient, because they had to leave the desk unstaffed if they needed to carry out any tests on patients in the department's triage room. This meant patients who arrived while the streaming desk was unstaffed may have had to wait for longer, until the nurse returned.
- Between 9am and 5pm, Monday to Friday, an operations manager was based in ED to monitor patient flow and liaise with other wards and units about discharges and bed space.
- When all of the majors cubicles were full, staff used minors cubicles as an overflow for urgent patients. We saw one patient who had self-presented at reception following a collapse. An emergency nurse practitioner assessed them in minors within five minutes of their arrival, and they had been seen by a consultant and underwent a computerised tomography (CT) scan within half an hour.

Learning from complaints and concerns

- Staff had access to the trust's complaints policy via its intranet.
- We saw leaflets about the trust's Patient Advice and Liaison Service (PALS) in the ED waiting room, where patients and visitors had access to them. The trust's website also gave information about PALS and how to raise a concern or make a complaint.
- We were given details of 10 complaints received by the trust, involving Royal Shrewsbury Hospital's ED, together with details of investigations and the trust's response letters to the patients and relatives. All personal identifiable information was removed from the records

before we viewed them. We saw responses were open and honest, and addressed each point made in each complaint in detail. Where necessary, mistakes were admitted and apologies were given. The letters evidenced a culture of detailed investigation and learning from complaints, to improve practice and future patients' experiences.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- Staff spoke very positively about the department's managers, and told us they were supportive and approachable.
- Staff were aware of and identified with the department's philosophy and the trust's values.
- Managers shared a comprehensive overview of staffing issues and departmental risks.
- A culture of mutual support and teamwork ran though all levels of clinical and non-clinical staff in the department.
- Managers were aware of, and focused on, areas in need of improvement. A structured improvement plan was in place and progress was being closely monitored.

Leadership of service

- The emergency departments at Shrewsbury and Telford were managed by the trust as one service. An operations manager based at Shrewsbury managed the logistical side of the department, supported by a deputy based at Telford. Each location had a matron who oversaw nursing and care services. Consultants and medical staff worked at both sites on a rota basis with the exception of some consultants who were contracted to work at one or the other of the sites and were therefore excluded from the rota.
- All the staff we spoke with, including nurses, doctors, healthcare assistants and non-clinical staff were very positive about the department's managers and consultants, and described them as extremely supportive and very approachable.
- One member of staff described the directorate managers as 'fantastic'. Another told us the department manager was 'amazing'.
- Senior staff in the department all told us they felt supported by senior managers in the hospital, and by the trust board.

Vision and strategy for this service

- The emergency department's philosophy was "We will provide timely emergency care based on your individual clinical need. Our team will deliver this with kindness, compassion and respect for all", and we saw it displayed on notice boards throughout the department. Managers told us staff were involved in writing the philosophy. Staff we spoke with were all aware of it and told us they identified with its sentiment.
- Staff were aware of the trust's values, which were 'proud to care, make it happen, we value respect, together we achieve'. They told us they could relate to the values and felt they fitted well with the way staff in the department worked.

Governance, risk management and quality measurement

- ED managers at both hospitals held operational management meetings fortnightly, alternating between the two sites. We observed one meeting, which was attended by the ED matron and manager, and two senior managers from the trust. Items discussed included medical and nursing staffing, ED and ambulance handover performance and the department's risk register.
- We were shown a copy of the department's 'integrated performance report', which gave managers details of ED's monthly figures on staff sickness and management, nineteen patient safety indicators, six patient experience indicators, staff training and appraisals.
- We were given a copy of the trust's 'rapid implementation internal ED improvement plan', which detailed 49 areas for improvement across the emergency departments in both hospitals. Each item was graded by colour: blue indicated the item was implemented and operational; green meant it was on track for implementation within the agreed timescale; amber showed it was in the planning stage; and red showed there was no evidence of progress.
- In December 2016, four of the 49 items were shown as 'blue', and nine were 'green'. Seventeen items were

'amber', showing they were in progress and only five were 'red'. Three of the 'red' rated items were not due for completion until March 2017; however two of them should have been completed in November and December 2016, so were overdue. These related to the implementation of a set of 'internal professional standards' and to undertake demand and capacity modelling by hour of the day and day of the week. The trust's chief executive reviewed the plan every month, at a meeting including all specialties from the hospital. This meant all departments were engaged with the ED improvement plan and that the key issues were being monitored and regularly reviewed.

- We were given minutes of the emergency care group's clinical governance meetings held from May to November 2016. Senior doctors and nurses, and non-clinical managers attended the meetings, during which they discussed matters such as audits, complaints, incident reports, trauma governance and 'thank you' cards from patients and relatives. The meeting minutes evidenced an emphasis on learning from incidents and patients' comments to improve patients' care and experience.
- The department held an annual sickness review with every member of staff, even if only to congratulate them on having 100% attendance.
- We were shown a copy of the department's risk register, which listed four 'very high' risks, two 'high' and one 'moderate' risk. The 'very high' risks related to poor patient flow through the department, the shortage of ED consultants and middle grade doctors and the restrictive size of ED cubicles. The 'high' risks were the number of paediatric trained staff, and the age and condition of the department's decontamination equipment. The moderate risk referred to the shortage of acute medical physicians in the hospital affecting patient flow through ED. All of the risks had been assessed in detail and graded, and action had been taken to mitigate the potential for harm.
- We were shown a folder of 59 risk assessments completed by one of the department's sisters. Each risk was graded using a system based on the severity of the potential harm versus the likelihood of it occurring, and actions were listed to reduce each risk where possible or mitigate the potential harm.

Culture within the service

- Staff told us they were proud of the ED team and the support they gave each other, and the way they cared for their patients. A healthcare assistant described their colleagues as a "great team" and told us they had plenty of support.
- A newly-qualified nurse told us other staff had been very supportive and helpful during their induction, and had made them feel welcome and part of the team. They told us the ED consultants were friendly, approachable and helpful.
- We observed a registered nurse speaking to a student nurse about a patient they were looking after. The registered nurse displayed a supportive attitude, and explained all of the acronyms and terminology used in the patient's notes without sounding condescending.
- Three junior doctors told us they were well supported by medical and nursing staff, and said there was a definite culture of team working.

Public engagement

- The quality board displayed at the entrance to ED provided patients and other visitors with the names and contact details of the department manager and the matron responsible for emergency care services at the hospital. It also showed details of the number of patients treated by ED, the department's performance in infection control audits, complaints, and 'Friends and Family Test' results.
- Between October 2015 and November 2016, the department received 8,378 responses to the NHS 'Friends and Family Test' patient experience survey. This represents a response rate of 22%, significantly better than the England average for emergency departments, which is 13%. In August and September 2016, the response rate was over double the England average, and in December 2015 the response rate peaked at 45%, over three times the England average of 13% for the same month.

Staff engagement

- Staff told us they were informed of any feedback from the NHS Friends and Family Test, or from the trust's social media accounts, if they were mentioned by name or otherwise identified. The department manager gave them copies or printouts of the feedback for their portfolios, and to go towards their revalidation.

- Staff told us they received the trust's newsletter by email, and were kept up to date with local issues through posters produced and presentations delivered by the matron.
- Staff told us the trust and department managers provided them with updates on the progress of 'Future Fit' whenever new information was available. They said managers understood the process was unsettling for them and did their best to share information as quickly as possible.

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 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.
- Staff used a 'smart' LCD screen to monitor patients in ED at Royal Shrewsbury and Princess Royal Hospitals. This allowed department co-ordinators and managers to have an overview of the two departments, and to track patients and their clinical conditions. Every member of staff was able to update the board, and every entry was confirmed with a PIN number unique to the staff member.

Medical care (including older people's care)

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

Information about the service

The medical care service at Royal Shrewsbury Hospital (RSH) provides care and treatment for general medicine, cardiology, dermatology, gastroenterology, thoracic medicine, haematology, respiratory medicine and nephrology. Together RSH and the Princess Royal Hospital have just over 700 beds and assessment & treatment trolleys.

The trust had 65,366 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 26,378 (40.4%), 37,633 (57.6%) were day case spells, and the remaining 1,348 (2.1%) were elective. Data showed that 25,198 (39%) of admissions were in general medicine. Data for the individual hospital sites was not provided.

This was a focused inspection, following up our inspection that took place in October 2014. The service was rated requires improvement for safe, effective and responsive.

During this inspection, we visited a range of medical wards at RSH. These were the acute medical unit, cardiology, rehabilitation, respiratory, nephrology, short stay and the supported discharge ward. We spoke with 24 patients and visitors, and 51 members of staff at different grades, as well as observing the daily routines of the hospital.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We spoke with 38 allied health care professionals.

Summary of findings

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.

Infection control systems and processes were adhered to by all staff and hygiene standards were routinely monitored.

Staff planned and delivered patient's care and treatment in line with current evidence-based guidance, standards, best practice and legislation.

Local and national audits of clinical outcomes were undertaken and quality improvements projects were implemented in order to continually improve patient care and outcomes.

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.

However, attendance levels for mandatory training were noted to be low in most areas in medicine and compliance with the trust target for completion of staff appraisals was below the trust target.

Medical care (including older people's care)

Ward staff were being supported on most shifts by agency and bank staff. There were insufficient consultant capacity (including vacant funded posts) in acute medicine.

Are medical care services safe?

Good

We rated safe as good because:

- Staff said they were encouraged to report incidents of harm or risk of harm, they were investigated appropriately and learning was shared.
- There were good examples of the statutory duty of candour.
- All staff we spoke with clearly understood the safeguarding policies and processes and were aware of their responsibilities to report concerns.
- Infection control systems and processes were adhered to by all staff and hygiene standards were routinely monitored.
- Although substantive nurse staffing levels throughout the medical directorate were below agreed planned numbers, the trust were able to ensure shifts were covered through bank and agency staff.

However:

- There was insufficient consultant capacity in medical services, the rotas were supported by locum doctors.
- Management did not display all of the results of the NHS safety thermometer on the wards we visited. This meant that staff were unable to measure, assess, learn, and improve on the safety of the care they provided.
- The resuscitation trolley was not consistently checked daily in line with the trust policy.

Incidents

- There were systems in place for reporting actual and near miss incidents across the medical division. Staff reported incidents and near misses through an online incident reporting form. Staff told us they had access to the form via the intranet and were confident in using it.
- The majority of staff told us they obtained feedback on incidents reported on both an individual but mostly service level. Learning was shared through channels such as the staff newsletter, clinical governance executive committee, team meetings and safety bulletins posted on staff information boards.
- Between October 2016 and September 2016 medical services at Royal Shrewsbury Hospital (RSH) reported no

never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. In accordance with the serious incident framework 2015, the trust reported 17 incidents in medical services, which met the reporting criteria set by NHS England between October 2015 and September 2016. Staff based at the RSH reported seven incidents serious enough to meet these criteria. Of these the most common type of incident was slips trips and falls.

- The service monitored its mortality rates on a monthly basis using four measures. These were 'The Hospital Standardised Mortality Ratio' (HSMR); a national measure for comparing a trust's mortality against other similar hospitals, 'The Summary Hospital-level Mortality Indicator' (SHMI); which also includes patients who die within 30 days of discharge ; 'Risk Adjusted Mortality Index' (RAMI), similar to HSMR but compares with a different group of hospitals and 'Crude Mortality' which includes all deaths in the hospital. We saw mortality was discussed from medical quality safety clinical governance meetings. The service reported on these to the trust board and to the quality and safety committee on a monthly basis.
- There were good examples of the statutory duty of candour. 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.
- Although most of the staff members we spoke with were unaware of the term duty of candour, all of the staff were able to explain they would admit when they made a mistake or when something went wrong and would always be open and honest with patients and apologise
- When serious incidents took place, the service held multidisciplinary meetings to analyse information, identify the root cause and contributory factors, and generate action plans. A root cause analysis (RCA) is a structured method used to analyse serious incidents.
- We reviewed a sample of RCAs relating to medicine. All investigations identified the root cause, included recommendations and had a timed action plan. For example, a serious incident occurred where a ward doctor prescribed a patient with cancer double the dose of medication. The pharmacy team did not identify the error when dispensing the discharge prescription. Action points arising from this incident included re-educating pharmacy staff on the dispensing and checking of medications and ensuring there was adequate cover from appropriately trained and experienced pharmacy technicians and pharmacists. This was to ensure a consistent approach to medicine management and reviews on the oncology ward and outpatient service.

Safety thermometer

- The safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections. This enables staff to measure, assess, learn, and improve on the safety of the care they provided.
- Data from the patient safety thermometer showed that the trust reported a total of 53 pressure ulcers, 20 falls with harm and 23 catheter urinary tract infections in medicine between September 2015 and September 2016. Data for the individual hospital sites was not provided.
- We saw that patient safety audit results and associated action plans were discussed in ward team meetings.
- Management did not display results of the NHS safety thermometer on the wards we visited to demonstrate to staff, patients and relatives the levels of harm-free care on the wards.

Cleanliness, infection control and hygiene

- The trust screened patients for Methicillin-resistant Staphylococcus aureus (MRSA) once they had been admitted to a medical ward. This supported their commitment to be fully compliant with the national screening policy for MRSA. MRSA is a type of bacteria that is resistant to a number of widely used antibiotics.
- All the staff we saw were well presented wearing clean uniforms and were observed to be following the trusts policy on arms 'bare below the elbow'.
- All staff members we spoke with were aware of the current infection prevention and control (IPC) practices and we saw they followed trust policies for hand hygiene, personal protection equipment and isolation.

Medical care (including older people's care)

- The hand hygiene policy was available to all staff via the trust's intranet. The trust target for hand hygiene compliance was 95%. Ward managers carried out audits of compliance every two weeks within all clinical areas on the medical wards. Audit results were reviewed by the IPC team and discussed at the trust's Infection Control Committee meetings. Action plans were agreed and the impact of these actions was monitored through the ongoing audit programme. Management increased the frequency of the audits to weekly when the compliance rate fell below 95%. Management also increased audit activity when the infection control team identified an outbreak or a period of increased incident of a particular organism on a ward. The overall compliance rate for 2015/16 was 97%.
- There were sufficient hand washing sinks, soap dispensers, hand gel, and towels and across the medical wards we visited.
- Staff used side rooms as isolation rooms for patients identified as an increased infection control risk. For example, patients with MRSA, and to protect patients with low immunity.
- During our last inspection in October 2014, we observed poor infection control techniques relating to cannula care in many areas. During our current inspection, we observed staff consistently followed the trust's policy and procedure.
- The trust's infection control team worked with wards and medical teams to support compliance with sampling, cleanliness and prescribing of antimicrobial medicines.
- The percentage of staff working in acute medicine who completed their infection prevention control training between April 2015 and March 2016 was 60%. Data for the individual hospital sites was not provided
- We saw 'Infection Prevention & Control Nurses Quality and Safety Ward Walks' documentation for the medical wards we visited. Areas audited included cleanliness, invasive equipment, and management of infected patients. The IPC team devised action plans for areas with an overall score of less than 80%. A follow-up 'quality walk' by the IPC team within 14 days would then be completed, to check on the progress of actions and improvements made.

Environment and equipment

- We saw that patient areas were free from trip hazards to ensure patient safety. Wards appeared tidy and organised.
- The medical wards we visited had enough equipment to meet patients' needs. This included pressure relieving mattresses and bariatric equipment. The trust replaced equipment in a prioritised way through the risk register.
- We saw resuscitation equipment in all ward areas. These units were unlocked and accessible.
- Daily checks were signed on the majority of days but not every day. The absence of some checks was brought to the attention of the relevant ward managers. The managers confirmed checks were meant to be completed daily in line with the trust policy. This issue was also raised on our previous inspection.
- We checked samples of consumable equipment on each ward or unit we inspected. We found they were all in date, and had appropriate, intact packaging.

Medicines

- We observed medicine cupboards and trolleys were locked and secured safely.
- Staff completed medication administration record charts correctly. We saw allergy sections were clearly completed in the charts.
- Each ward had access to a pharmacist and a pharmacy technician.
- Pharmacy support for wards was available on-site Monday to Friday from 9am to 5pm, with an on-call service outside of these hours.
- A trust wide 'Safe Medication Practice Group' met every two months. A multi-disciplinary team, including staff from the medicine directorate at RSH, the nurse manager, chief pharmacist and patient safety team attended. The minutes we reviewed showed the team discussed areas such as complaints and never events and generated action points to address areas for improvement.
- There were suitable arrangements in place to handle, store and administer controlled drugs (CDs). Staff recorded regular checks of CD balances. We reviewed a substantial amount of entries on the register and saw that two nurses, with a separate signing sheet, audited CDs on a daily basis. Staff correctly documented CDs in a register, which was in line with the National Institute of Health and Care Excellence (NICE) guidelines.
- We saw evidence that staff regularly checked and recorded fridge temperatures to ensure that they were

within the correct range for the suitable storage of drugs. A policy was in place on what actions to take if staff found temperatures to be outside of the correct temperature range.

- In May 2015, the West Midlands Quality Review Service conducted a local health economy review within Shropshire and Telford & Wrekin, into the way in which patients were transferred from the acute hospital setting into intermediate and community services. From the review, a number of improvements were identified that could be made in the way in which they supplied patients with medications on discharge from hospital. In response, the trust used a rapid improvement approach to how medication was dispensed and delivered to patients on the ward. We have no data to evidence whether the approach worked.

Records

- Patient records on all of the wards we visited we checked contained risk assessments, records of care and treatment and were legible, signed and dated.
- We found that patient records were kept securely on every ward we visited. This meant that unauthorised persons could not remove or view records without staff knowing.
- We reviewed 15 sets of prescription charts on three of the wards we visited. Every single chart was legible, signed, dated and completed correctly.

Safeguarding

- There has been an agreed adult safeguarding policy and procedure throughout Shropshire, Telford and Wrekin since April 2013. All agencies within the local adult safeguarding board, including RSH, had adopted this policy.
- There were 48 safeguarding referrals made by staff based at RSH between December 2015 and December 2016. Staff we spoke with were fully aware of how to refer a safeguarding issue.
- Staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 100%. Between September 2015 and November 2016, medical services achieved 58% in safeguarding adults and 44% in safeguarding children. Data for the individual hospital sites was not provided.
- Staff told us that patients who staff knew were at risk of wandering wore roam alerts to protect their safety. This meant that staff were alerted to their movement and whereabouts, keeping them mobile yet safe.
- Medical staff we spoke with told us the safeguarding lead nurse for the trust advised staff when reporting incidents and was very supportive. The lead nurse supported nurses when attending adult safeguarding meetings.
- A monthly ward staff meeting took place with the named doctor and named nurse for safeguarding to enable learning, improvement and training for staff. It provided an opportunity for medical and nursing staff to learn from cases where child protection or safeguarding had been an issue.

Mandatory training

- Mandatory training for all staff included subjects like safeguarding, infection prevention and control, moving and handling, fire safety and security. The trust had a target of 100% compliance with mandatory training.
- Mandatory training compliance rates ranged from 57% to 91% on the different topics across medicine at RSH. For the year 2015/2016 the coronary ward achieved 91%, stroke and rehabilitation 71%, respiratory ward 57%, nephrology ward 68%, short stay ward 89% and 75% on the support discharge ward.

Assessing and responding to patient risk

- The trust used a national early warning system (NEWS) in medicine to highlight significant changes in patients' medical conditions. An electronic handheld device, was used to record and monitor these patient observations. The system used the data input to calculate a score, a measure of risk for each patient. The system used these scores to alert the staff to patients who may be deteriorating, as well as recording when staff should take the next set of observations, according to the patient's individual level of risk.
- The Situation, Background, Assessment and Recommendation (SBAR) technique was used by medical and nursing staff. This helped staff to share patient information in a clear, concise, and structured format, therefore improving communication and accuracy.

Medical care (including older people's care)

- Staff completed and recorded comfort rounds on each ward to ensure patients' comfort and safety. These took place every one to four hours and were audited by the ward manager.
- We reviewed 15 sets of notes across three of the wards we visited and saw staff had fully completed pressure ulcer prevention and falls risk assessments where staff had identified risks.
- We were told Ward 28, the respiratory ward had introduced a bay watch scheme. This ensured a 'bay watcher' was always present to prevent falls during the day and night for high risk patients.

Nursing staffing

- The trust used the Safer Nursing Care Tool(SNCT) to determine nurse staffing levels in all areas as part of a six-monthly review process. The tool did not take account of patient acuity.
- Each medical ward in the hospital displayed a "staff information" poster, which showed the planned and actual number of registered nurses, midwives, and care staff on each shift that day. They also showed who was in charge of each shift and when management had last updated the poster. Figures showed that management maintained staffing numbers with a high reliance on bank and agency staff.
- We were told that the matrons monitored actual versus planned staffing levels across the service on a daily basis to ensure that they took appropriate action to mitigate risk when there were staffing shortfalls.
- Average fill rates for registered nurses in November 2016 during the day were 110% in the acute medical unit (AMU) , for the support discharge ward it was 91%, the rehabilitation unit achieved 88%, the cardiology ward was 95%, the respiratory ward was 88%, the nephrology ward was 86%, and the short stay ward was 83%. Where the fill rate is above 100%, this means that more staff worked on the ward in the month than planned. This may be due to reasons such as an increase in patient care needs, for example, where a patient may need one to one nursing care and/or where a patient has become more acutely unwell. Where the fill rate is below 100%, this means that there have been some gaps in staffing on some shifts during the month. Generally, this may be due to a staff vacancy that cannot be covered by existing staff or unplanned sickness absence that has not been able to be covered by temporary staff.
- Average fill rates for registered nurses in November 2016 at night were 113% on AMU, for the support discharge ward it was 100%, the rehabilitation ward achieved 98%, the cardiology ward was 80%, respiratory ward was 100%, the nephrology ward achieve 98 % and the short stay ward was 84%.
- Staff carried out end of the bed and 'bay entrance' handovers, (forms of communication between nurses caring for patients on one shift to the next at the end of a patient's bed or at the entrance to the patient's bay) depending on the sensitivity of the information. We saw that nursing staff used a printed patient handover sheet that staff updated before each shift.

Medical staffing

- There was consultant presence in the hospital between 9am to 5pm Monday to Fridays. On weekends there was consultant cover between 9am to 3pm. Outside of these hours there was emergency on call consultant cover.
- Advanced care practitioners (ACP) undertook physical and/or mental health assessment of medical patients with acute care needs. They could assess patients, request and interpret diagnostic tests, diagnose and plan and deliver care. They also work alongside the multi-disciplinary team to prescribe medications and work independently where necessary.
- ACPs began at 0900hrs and finished at 1700hrs Monday to Friday. There was no weekend cover. In the mornings the ACP performed AMU ward rounds. In the afternoon, one ACP covered the medical on call until 1700hrs when relieved by the evening consultant. One ACP covered the ambulatory emergency care unit (although GP's provided support on both sites for approx. 3 days of the week).
- The trust was aware that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. Locum doctors were on the rota to support the team. This issue was identified in our inspection in 2014.
- The ongoing concerns about medical staff, recruitment and associated patient risk because of current staffing levels was reviewed through clinical quality review meetings. Acute and medical care (including older people's care) continued to be among the greatest areas of risk as was highlighted on the risk register. The trust reported that it was continuing work with other organisations and relevant professional bodies to identify sustainable solutions going forward.

Medical care (including older people's care)

- Out-of-hours cover for weekends and nights was the responsibility of the FY1 (a grade of medical practitioner undertaking the Foundation Programme) and the CT2 (a senior house officer).
- Consultant ward rounds took place on all wards five days a week.
- Locum medical staff received a full induction. We saw the induction pack and it covered areas such as incident reporting, health and safety and safeguarding.

Major incident awareness and training

- The trust had in place a major incident plan. This set out guidance on roles and responsibilities and how the hospital and individuals would respond. The trust also had a number of business continuity plans to ensure maintenance of the essential services to the patients.
- Management staff in the medicine team tested these plans regularly using variety of processes to ensure they responded efficiently and effectively.
- The trust were part of the West Mercia Local Resilience Forum (WMLRF) which is a partnership, comprised of a number of organisations, with the responsibility of preparing for and responding to major incidents.

Are medical care services effective?

Good

We rated effective as good because:

- Staff planned and delivered patient's care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- Local and national audits of clinical outcomes were undertaken.
- Staff met patient's pain relief, nutrition and hydration needs.
- Most patient outcomes were similar to or better than national targets. Where outcomes were lower, there was evidence of action to improve.
- There were seven days services with access to therapy services at weekends.
- There were good examples of multi-disciplinary working.
- Staff obtained patient's consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005. Staff supported patients to make decisions and, where necessary, staff appropriately assessed and recorded their mental capacity.

However:

- The trust were not submitting data to national audits on lung cancer and myocardial ischaemia.
- Compliance with the trust target for completion of staff appraisals was below the trust target.

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. For example, the trust completed an AMU antibiotic prescribing audit. Findings showed compliance to antibiotic guidelines were generally good with reasonable justification when staff had not followed them. However, the trust found negative findings concerning times taken for septic patients. We saw an action plan in place to address these findings such as doctors to flag up patients who they have prescribed antibiotics to nurses to help with prompts for administration.
- Care pathways were implemented in accordance with NICE guidance, such as the stroke pathway.
- Patients were assessed on admission and risk assessments were put in place to reduce the risk of harm such as falls and pressure ulcer development.
- The endoscopy departments at RSH completed their JAG return for April 2016. JAG requires notification every six months of adherence to standards covering safety, quality, training, workforce and customer care. All standards were met, except timeliness and consent, the latter being a new standard which the trust reported they were in the process of implementing.

Pain relief

- The acute pain team provided support and advice in the management of acute (severe) pain for adult inpatients during their hospital stay on medical wards.
- Patients were asked to describe their pain to staff using a pain scale. Staff used the information to assess patients' pain and had recorded this on patient notes.

- Patients we spoke with said they were asked whether they were experiencing any pain and received timely pain relief if needed.

Nutrition and hydration

- Dietitians provide nutritional assessment and treatment plans for patients in the acute hospital setting including food/nutrient/drug interactions, enteral feeding, and food fortification.
- We saw patient's food charts completed correctly with entries for every mealtime.
- We reviewed five patient records and found that malnutrition universal screening tool (MUST) risk assessments were completed.
- Patients we spoke with said they were happy with the variety, choice and standard of food. Food choices on the day we visited included a wide variety of choices. For example, breakfast included choices of fresh juice, fresh fruits, wholemeal or white bread, four different kinds of cereals, butter or margarine, jams , marmalades and diabetes jams and marmalades. All items on the menu had vegetarian diabetic high energy and healthy heart options which were highlighted to patients by symbols. There was also a box to tick if the patient needed assistance with feeding.
- Snacks and drinks were available throughout the day. Snacks included biscuits, bread and toast.
- A restaurant was on site at the RSH which patients could access.
- Dietitians provided nutritional assessment and treatment plans for medical patients including food/ nutrients/drug interactions, enteral feeding (delivery of a nutritionally complete food directly into the stomach,) and food fortification (addition of key vitamins to staple foods to improve their nutritional content).
- A red tray system was in place to alert staff to help patients who needed assistance with feeding.
- Protected mealtimes were in place to focus ward activities into the service of food, providing patients with support at mealtimes. The protected mealtime philosophy focuses not only on the quality and nutritional value of food but also the patients' experience of eating.

Patient outcomes

- The results in the 2015 Heart Failure Audit were better than the England and Wales average for all of the four of the standards relating to hospital care. The hospitals results were better than the England and Wales average for six of the seven standards relating to discharge. Cardiology inpatient at the RSH scored 53% against the England average of 49%, input from consultant cardiologists was 63% against the England average of 60%, input from a specialist achieved 100% compared to the England average of 78% and patients receiving an echo achieved 100% compared to the England average of 92%.
- ACEi (Angiotensin-converting enzyme inhibitors) and ARBs (Angiotensin II receptor blockers) are drugs that help to improve survival of patients with heart failure and staff should prescribe them to patients on discharge as appropriate. The audit showed that the hospital was better than the England average for prescribing these drugs on discharge and referral to a heart failure liaison service achieved 99% compared to the England average of 59%. However, referral to cardiology follow up only achieved 47% compared to England average of 100%.
- The trust did not take part in the MINAP (Myocardial Ischaemia National Audit Project) audit. This is a national clinical audit of the management of heart attack. The trust did not take part in the national lung cancer audit.
- The RSH took part in the national diabetes inpatient audit in 2015.They scored better than the England average in nine metrics and worse than the England average in eight metrics. The indicator regarding 'insulin areas' had the largest difference compared to the England average (trust score 38.5% higher).
- Between March 2015 and February 2016, patients at RSH had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions.
- The trust was working to improve care for patients, 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 patients' 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.
- The trust was also working on the treatment of sepsis. Staff reported a 92% reduction in time from diagnosis of sepsis to commencement of all elements of the sepsis

bundle (296 to 23 minutes); 100% of patients received all appropriate elements of the sepsis bundle within one hour; a reduction in steps taken by a patient reduced from 84 to 22 steps before they were reviewed for signs and symptoms of sepsis and the time to complete nursing documentation associated with the screening and diagnosis of sepsis reduced by 84% (45 to 7 minutes).

- The trust completed an asthma audit in 2015/16. An action point arising from this audit meant that respiratory nurses were now regularly visiting ward patients to ensure better recognition of an increase in the severity of asthma (exacerbation) across all admissions.
- An audit of multiple sclerosis (MS) found that the trust was unable to meet the targets to see GP referrals within six weeks and to meet target time from first outpatient appointment to diagnosis for many patients. Action points were for the trust to see GP referrals within 6 weeks and for staff to establish the diagnosis of MS and inform the patient within 12 weeks.

Competent staff

- Data provided by the trust showed that for the period September 2015 to November 2016, 96.% of doctors in medicine had an up to date appraisal with the rate for speciality and associate speciality doctors at 96% and consultants at 97%. The target compliance level for appraisal was 100%.
- Data provided by the trust for the period September 2015 and November 2016 showed that on average, the appraisal rate for nursing staff in medical services was 75% against the trust target of 100%. This ranged from 96% on the coronary care ward to 43% on the respiratory ward.
- All staff members working on the medical wards had a personal development plan agreed with their line manager at their annual appraisal. In this way, line managers helped identify areas which could be supported to help staff perform at their best and deliver excellent services to their patients
- Processes for identifying doctors due for revalidation were in place with clear guidance provided for new staff in the trust. The trust provided information on the medical director's information pages on the intranet regarding appraisal and revalidation.
- Management sent exception reports for staff who had not achieved their revalidation (due and overdue) to the care group medical directors and human resources (HR) business partners on a monthly basis to discuss at the care group monthly board meetings.
- Nurses were supported with revalidation. To facilitate revalidation process for nurses, they had access to an online library. Nurses needed to demonstrate 40 hours of continuous professional development (CPD) of which part of it could include reading and reflecting on professional reading. Library staff were available to help staff locate suitable articles, guidelines or reviews from resources such as the NHS Healthcare Databases, Cochrane Library, or NICE Evidence.
- In 2015/16 there were 119 revalidation recommendations and 21 revalidation deferrals.
- Agency staff completed an induction when they arrived on the ward. In some areas, temporary staff had been block booked to enhance a consistent team of ward-based staff.
- We saw the temporary staff local induction document. It included areas such as location of the pharmacy, ward top up ,controlled drugs, drug rounds (including. specific /unusual medication), role and administration of I.V.s, health and safety brief and an ID check.
- Some trained agency staff had completed the trust competency skills assessment, allowing them to complete high-level tasks such as giving intravenous drugs.

Multidisciplinary working

- The trust used a patient status at a glance (PSAAG) to support a case management approach in MDT meetings. PSAAG combined the information from handover, electronic observations, nursing assessments, and bed information enabled staff to see, at glance rolled-up summary information on each ward.
- We observed handover meetings and board rounds. We saw that there were staff from all areas such as doctors, healthcare assistants, nurses and therapists that were involved in patient care and that they had input to the meetings.
- Clinical specialist nurses provided patient support and education. They also supported staff and aim to deliver improving care standards. They also liaise with other health care professionals when required. For example diabetes nurses regularly visited ward areas / departments across both hospital sites to provide

specialist advice for both staff and patients under the guidance of diabetes consultants. They were responsible for supporting ward staff / departments in delivering a high standard of diabetes care. They also provided teaching sessions.
- The Care Closer to Home Therapy Centre provided a range of countywide services delivered by multidisciplinary teams of Physiotherapists, Occupational Therapists, Speech & Language Therapists, Dietitians and Assistant Practitioners. The team worked closely with community colleagues in health and social care and voluntary organisations to ensure patients received effective treatment and co-ordinated care in the most appropriate location.

Seven-day services

- Seven day services were provided either with core service time or emergency/on call by microbiology, blood sciences, a consultant haematologist, pharmacy services and radiology.
- During the winter period, a range of therapy services were available for four and a half hours on Saturdays, Sundays and bank holidays. This included occupational therapy, a physiotherapy discharge service, physiotherapy orthopaedic service and occupational therapy and physiotherapy stroke service.
- In general medicine there was an on-call/acute medicine twice daily (continuous assessment) AMU ward rounds seven days a week
- In speciality medical services renal provided a seven day category B on call service. Cardiology provided seven day category A on call service and seven day ward rounds (Saturday RSH, Sunday PRH or vice versa) Gastroenterology provided seven day category A on call service and seven day ward rounds (Saturday RSH, Sunday PRH or vice versa)
- Admitted medical patients received an early consultant assessment 7 days a week.
- There was access to cardiology, gastroenterology, and renal services 7 days a week

Access to information

- Staff at all levels had access to the hospital's guidelines, policies and procedures through the internet.
- We saw an electronic board system, which displayed patient information and allowed quick and easy access for all staff. The board allowed easy referrals to be made and the information was up to date so staff could assess each patient's needs in real time. The system made discharging and transfer of patients efficient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of their responsibilities around the Mental Capacity Act and deprivation of liberty safeguards. They were able to demonstrate a good understanding of the process. The trust had policies on both these issues, along with a policy on consent.
- The mental health team attended the wards on request to support patients to make best interest decisions if needed.
- We observed patients being asked for verbal consent before procedures were carried out.
- The Shropshire local authority trainer and safeguarding lead for Shropshire CCG arranged to visit three wards at RSH. The purpose of this visit was to determine the effectiveness of the training provided and to embed the Mental Capacity Act (MCA) into staff members practice. The feedback received was positive. It found that there was good practice of the MCA including assessments and best interest decisions. However, at times the wards did not always recognise that they were assessing for capacity when delivering personal care.
- During our unannounced inspection we looked at one patient record who's capacity had been assessed and a DoLS application had been made. All the documentation was clear legible and correctly completed.

Are medical care services caring?

Good

We rated caring as good because:

- We saw and patients and relatives we spoke with consistently told us that staff were kind and caring.
- We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy.
- Patients we spoke with were complimentary and full of praise for the staff looking after them

Medical care (including older people's care)

- There was a clear understanding of relatives and visitors.
- There was a range of emotional support options available to patients and those close to them

Compassionate care

- The friends and family test (FFT) response rate for medical care at the RSH was 22%. Survey results for 2015/2016, showed that 96.4% of inpatients would be likely to recommend the ward staff who treated them to friends and family if they needed similar care and treatment. Where percentage recommended scores were reported they were generally greater that 90%. The lowest reported score was for Ward 27, the respiratory ward at RSH in May 2016, which was 75%.
- All of the patients and visitors we spoke with had nothing but praise for the care they had received from staff at all levels. This supported the FTT scores and what we observed.
- We saw several compliment cards and letters from grateful patients and relatives.

Understanding and involvement of patients and those close to them

- Both patients and their relatives/carers spoke highly of staff looking after them at RSH. They felt listened to and involved in all aspects of their care.
- The trust provided all patients with a copy of the letter that staff sent to their GP, including their medications, what treatment the patient had received whilst in hospital, the trust's findings and what the plan was for follow up care. The trust measured how well they were delivering this by surveying their patients each quarter. Staff gave every patient a patient handbook that provided all the information they needed during their stay at the trust.
- Provisions were made for relatives and carers of vulnerable patients with additional needs such as learning disabilities or dementia to visit outside of normal visiting hours.
- Relatives/carers were able to telephone the ward outside of visiting hours to receive an update on their loved ones progress in hospital.
- The trust had an E-Card service on their website. It was a free feature that allowed relatives/carers to send hand delivered cards to patients. It was available for any inpatient at RSH.

Emotional support

- The hospital chapels were open 24 hours a day for patients, staff and visitors. It provided a place for people to reflect, pray or just to have some quiet time. There was a pebble pool in place of candles. For people of Muslim faith, there were washing facilities, prayer mats and a sign locating the direction of Ka'bah.
- Clinical nurse specialists were employed across many areas such as stroke, lung cancer and diabetes. A clinical nurse specialist (CNS) is a healthcare worker who can provide expert advice related to specific conditions or treatment pathways.
- At RSH, the Hamar Help and Support Centre provided counselling and support services to patients with a cancer diagnosis, their family and carers.
- The Macmillan Information and Support Centres offered people affected by cancer access to appropriate information and support for all stages of the cancer journey.
- The renal service offered referrals to a psychologist. The psychologist could help with areas such as coming to terms with a diagnosis and adjusting to the lifestyle changes that may be required and adjusting to the treatment regimen and undergoing medical procedures which make the patient feel worried or upset.
- A bereavement officer was available during normal office hours Monday to Friday. They provided a caring and compassionate service, offering support and reassurance, information and guidance.

Are medical care services responsive?

Good

We rated responsive as good because:

- Between September 2015 and August 2016 the trusts referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance.
- The trust exceeded their cancer waiting targets
- There was service planning and delivery to meet the needs of the local population.
- The service had good arrangements in place to ensure that the needs of patients living with dementia were met.

- There was openness and transparency in the management of complaints. Complaints and concerns were taken seriously and improvements made.

However:

- The medical outliers buddy system sometimes missed patients, at weekends.

Service planning and delivery to meet the needs of local people

- The medical directorate had one service level agreement with an external provider. This was for the provision of a subcontracted dermatology two week wait (skin cancer) outpatient and day case service. The SLA was comprehensive and up-to-date.
- The Commissioning for Quality and Innovation (CQUIN) payment framework had set targets for the trust to meet. The framework supports improvements in the quality of services and the creation of new, improved patterns of care. We saw evidence of CQUINs directing service planning and delivery. For example, the medicine directorate contributed to the collection of monthly Mixed-Sex Accommodation (MSA) breaches. We saw that medicine wards were set up to ensure male and female patients were cared for in separate areas. CQUINS were also imposed to meet the needs of other patient groups such as dementia patients and those at risk of sepsis.

Access and flow

- Between April 2015 and March 2016, the average length of stay for medical elective patients at RSH was 3.5 days. This was lower than the England average of 3.9 days. For medical non – elective patients the average length of stay was 6.3 days. This was similar to the England average of 6.6 days.
- The three main reasons for delayed discharges were delays in domiciliary provision, nursing/residential care provision and an increase in non-acute care such as rehabilitation. The majority of the trusts patients lived in three local authority areas. One of these was Powys County Council in Wales. During our visit, staff referred to the 'welsh factor' when discussing reasons for delayed discharges. Some staff members told us Welsh social workers were not authorised to enter and undertake their duties in English hospitals, therefore this caused a unique challenge this particular group of patients.
- The West Midlands Quality Review Service published its report in September 2015. They audited transfer from acute and intermediate care. The purpose of the visit was to review compliance with the West Midlands Quality Review Service (WMQRS) Quality Standards: (Transfer from Acute Hospital Care and Intermediate Care, V1 August 2014) Several examples of delays in transfer of care of patients from Powys were given to reviewers during the course of the visit, including problems with equipment supply and difficulty discharging patients with tracheostomies**.** The impact was that patients stayed in acute beds longer than necessary, impacting on the capacity available for other patients. **A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help patients breathe.**
- In early 2016, staff on three hospital wards at RSH took part in a multidisciplinary accelerated discharge event (MADE) to help patients who no longer need to be cared for at the hospital be discharged earlier. The purpose of the campaign was to deliver a unified whole-system approach where patients who no longer required an acute level of care could be safely discharged. The trust reported that this generated a number of additional discharges earlier than anticipated.
- Between September 2015 and August 2016 the trusts referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance. The latest figures for August 2016 showed staff treated 100% of this group of patients within 18 weeks. The following specialities were above the England average for admitted RTT (percentage within 18 weeks). Cardiology achieved 93.3% compared to the England average of 85.7%, dermatology achieved 100% compared to the England average of 88.4%, gastroenterology achieved 100% compared to the England average of 94.7%, thoracic medicine achieved 100% compared to the England average of 96.4 % and general medicine achieved 95.6% compared to the England average of 5.9%.
- The trust exceeded their cancer waiting targets in all areas for year ending 31 March 2016. Two-week GP referral to first outpatient was 95%, 2-week GP referral to first outpatient for breast symptoms was 95%. For the target of 31 days from diagnosis to treatment for all

cancers the trust achieved 98%., For 62 days from urgent GP referral to treatment of all cancers was 85%, 62 day referral to treatment from screening was 96%, 62 day referral to treatment from hospital specialist was 89%.

- Due to high demand for medical beds, there were medical patients in surgical beds across the hospital. The trust had implemented a buddy system to ensure staff did not miss these medical outliers on surgical wards. This is where an assigned medical wards looks after outlining patients on another ward until an appropriate bed becomes available, although we were told that the surgical assessment unit at RSH did not have a buddy.
- We reviewed the patient records of four patients classed as outliers. We found that one patient had not been seen for three days as staff admitted them on Friday and the consultant had not been to see them over the weekend. Staff on the unit were aware of this and told us this was not unusual for patients who were admitted over weekends to not be seen. The number of medical outliers trust wide between June 2016 and December 2016 ranged from 1459 to 1799.
- As part of the trust's internal improvement plan work began on improving patient flow by reducing the average time it took to process patient medication. In 2016, the trust introduced an enhanced ambulatory emergency care model on both sites. The aim of this was to reduce the number of patients needing an emergency admission by providing a medical day case type service. This service provide care for older patients who require a short stay in hospital due to symptoms associated with frailty such as falls, dehydration, immobility and delirium. The trust was planning to develop this further in 2017 to include a 72-hour frailty service.
- An ambulatory care unit at RSH had reduced the time patients with respiratory disease waited to be assessed and treated by 50%. This meant more patients were seen and treated quickly without being admitted to an inpatient bed.
- During the winter period, a range of therapy services were available over the weekends and bank holidays to facilitate earlier discharge either over the weekend or within two days of receiving therapeutic treatment. This included occupational therapy, a physiotherapy discharge service, physiotherapy orthopaedic service and occupational therapy and physiotherapy stroke service.

Meeting people's individual needs

- Translation services were available for patients whose first language was not English, this could be accessed by telephone or face to face. Staff told us they knew how to use this service. We saw information leaflets for patients on a variety of topics/conditions.
- 'First Fit' clinics, allowing speedy and standardised assessment of patients with epilepsy. First Fit clinics patients were referred directly from the emergency department or by their GP. Clinics were led by a consultant neurologist who would review the medical information and where necessary, refer the patient for further tests. If epilepsy was not the cause,the patients would be discharged to their GP, or if necessary, referred to a different health professional. If the cause was uncertain, they would be followed up by the neurologist or a specialist epilepsy nurse based at the neurology centre or in the community. If epilepsy was diagnosed, after discussion, treatment may begin and the patient would have follow up appointments with the neurologist or specialist epilepsy nurse based at the neurology centre or in the community.
- Three NHS trusts from Shropshire had joined together in a bid to ensure patients got a good night's sleep in hospital. The trust came up with the 'Quiet Night – Sleep Tight' charter, which listed ways in which staff could make a difference. The trust also developed sleep packs for patients who were having trouble sleeping, which contained ear plugs and an eye mask to aid a restful night. These were available to patients on medical wards at RSH.
- A campervan with a portable dialysis machine parked outside the Royal Shrewsbury Hospital for two days. A different renal patient treated themselves inside the campervan each day to demonstrate some of the advantages of home dialysis. Dialysis patients had to visit the renal unit three times a week for treatment that could last between three and a half and four and a half hours each time. Self-treating at home offers patients more flexibility, although it is not suitable for everyone.
- The trust had recruited a dementia clinical nurse specialist to promote good practice, support staff training and to work with carers and other healthcare staff to promote and improve the care of patients living with dementia.
- The clinical nurse specialist had set up a new approach to caring for patients living with dementia with two

newly recruited dementia support workers. Work was under way within wards to roll-out and further embed the Butterfly Scheme and the Dementia Care Bundle. The Butterfly Scheme was introduced in 2014. It 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.

- Carer's passports were given to families and carers of vulnerable patients. This gave them the opportunity to visit outside of usual visiting hours to provide their knowledge of the patient to support the delivery of care to them in the most effective way.
- The trust had improved the environment on some wards to make them dementia-friendly. For example, on the elderly care ward, the trust had transformed a room into a 1950's style living room. It was furnished with furniture and décor from the fifties era. This provided dementia care patients with a nostalgic atmosphere which aided relaxation.
- The trust ran one and two day dementia awareness courses which many medical staff told us they had attended. Dementia awareness was part of the staff induction process.
- Staff told us about the 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.
- Volunteers from agencies such as the women's institute knitted twiddle muffs. Twiddle muffs are cosy, knitted tubes of wool into which patients can put their hands as they rest them on their laps. Attached to the inside and outside of the muff are buttons, ribbons, beads, keys etc, designed to encourage patients to keep their hands busy, and to help stimulate their mind.
- A learning disabilities nurse specialist supported patients with a learning disability diagnosis.

Learning from complaints and concerns

- The complaints procedure was clearly assessable on the trust's website.
- Acute medicine received 41 formal complaints between April 2015 and March. This equates to 0.4 per thousand beds. This was a significant fall from the previous year where nearly 70 complaints were received.
- Staff told us that they would direct patients to the nurse in charge or to the Patient Advice and Liaison Service team if they had a concern they could not resolve immediately.
- Ward managers told us they would try their best to resolve concerns as they arose. However, if this was not possible the patient would be advised to follow the trusts complaints procedures and the appropriate written information would be provided.
- The trust was required to acknowledge all responses within three working days, in line with their trust policy. The trust achieved 100% compliance with this requirement between April and September 2016.
- Staff told us that complaints and associated learning outcomes were discussed through channels such as team meetings and newsletters.

Are medical care services well-led?

Good

We rated well-led as good because:

- The medical directorate had embraced new innovative methodologies such as the partnership with Virginia Mason Institute (VMI) and they had developed their own new initiatives.
- Management complete national and clinical audits to find out if healthcare was being provided in line with standards and quality improvement projects were undertaken to continually improve patient care and outcomes.
- The majority of staff we spoke with felt able to raise concerns and were confident that these would be listened to.
- Staff were generally positive about relationships with the local leadership particularly with their line manager.
- There was a positive open culture within teams. We spoke with staff who demonstrated pride and compassion in the care that they provided.
- Staff were encouraged to put forward ideas for improvement through channels such as the VMI project

However:

- Staff told us that they did not see senior members of staff, above the level of matron, on the wards.

Leadership of service

- Medical care was part of the unscheduled care group. The leadership team comprised of an assistant chief operating officer, care group medical director and care group head of nursing (interim joint post). They linked to the executive team for the trust and had oversight of both medical services across the trust.
- Staff told us they felt supported by local leaders and we observed good communication between them. On many occasions nurses told us that they felt able to raise concerns with senior management and were listened to.
- The leaders we spoke to demonstrated an understanding of the challenges to good quality care and were able to identify the actions needed to address them. For example, managers were aware of the staff shortages and the impact upon patient care. Actions put in place to address this included block booking agency staff to ensure they were fully staffed at all times in the short term and ongoing national and international recruitment programmes.

Vision and strategy for this service

- The trust vision and values were available to staff on the intranet. We saw a statement – Proud to CARE, make it HAPPEN, we value RESPECT and together we ACHIEVE, used on documentation and posters to share the message.
- Even though staff were not necessarily able to recite the trusts vision and values they told us they were committed to providing the best patient focused care at all times.
- The trust had embedded employee- led values-based appraisals and medical staff completed a values based corporate induction programme.
- We saw an article in the newsletter written by the chief executive setting out and explaining the trust values and how it related to the trust aiming to provide the safest and kindest care in the UK.

Governance, risk management and quality measurement

- Governance systems were in place to identify risks and quality oversight. The unscheduled care group held governance meetings, which feed into the senior management processes. For example, medicine had its own risk register which was used to identify risks to its department, and these were reviewed at board level.
- We saw the trust's risk register for medicine and associated actions plans. A risk register is a tool for documenting risks, and actions to manage each risk. For example one of the risks registered was that the trust had a number of specialities which suffered from a significant shortage and inability to recruit in to funded posts due to a national shortage compounded by local/ rural issues. Identified actions required were to explore alternative workforce options, and to progress whole service workforce business case and recruitment plan. This is in line with the concerns we identified around safe staffing levels. It was evident that the management team were aware of the key challenges for the service and were working to resolve them.
- Clinical quality monitoring and the care quality group were led by the executive medical director and executive chief nurse. These groups reported to the board of directors and provided additional assurance and accountability around clinical quality and patient experience cross the medical directorate
- The director of unscheduled care focussed on the quality and clinical outcomes in clinical care.
- We saw that clinical audits and related action plans were completed across the medicine directorate to improve patient care and outcomes. For example, an accuracy of discharge summaries re-audit led to an action plan where the lead consultant was liaising with head of pharmacy to redevelop the discharge summary to include additional items that the audit highlighted. An audit of AMU antibiotic prescribing led to an action plan of continual education taking place around the antibiotic prescribing policy.
- 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.
- Ward managers attended monthly governance meetings where incidents and complaints were discussed and any lessons learned shared. We saw minutes from these meetings along with a newsletter that was circulated to inform staff.

Culture within the service

Medical care (including older people's care)

- Although a "disconnect" was described between ward staff and executives, all the staff we spoke with felt supported by the matrons and ward manager/sisters.
- The culture overall was a positive one with patient care a high priority for staff and they were proud to talk about the hospital.
- Staff we spoke with told us they were encouraged to report incidents and spoke of how they would be open and honest with patients when something went wrong and would offer an apology. All staff working in the medical directorate had access a variety of different mediums to support their health and well-being such as exercise classes , paid access to on site gyms and a range of discounts through a national website for healthcare providers.

Public engagement

- The trust invited the public to visit stands located around RSH on the 20 May 2016 where the trust had information on the current studies and how to get involved.
- The trust held dementia friend awareness days which the public could attend.
- The 'Ok To Ask' campaign encouraged patients, carers and the public to participate in clinical research, and to ask their doctors about research they might be able to take part in, which included medicine.
- The role of the volunteer was a vital role within the medical directorate, working in a variety of departments alongside staff. They were involved in a wide range of areas including chaplaincy, ward helpers, dementia activities and mealtime buddies.
- We spoke with one patient representative who was based at RSH and she was able to explain clearly her role in ensuring that the views of medical patients, carers and families were taken into consideration when planning / developing services.
- The trust involved the pubic in many areas relating to cancer services. For example, a patient experience and involvement panel member sat on the monthly cancer board, a patient speaks at the twice monthly cancer health & wellbeing events, an open house event for world cancer day was held annually which captured patient stories, patients participated in national cancer patient experience survey and annual local cancer patient experience survey and former patients and patient carers were part of the volunteers supporting the Macmillan cancer information and support centres.

Staff engagement

- The trust newsletter updated staff on current issues. Ward meetings were held to discuss local issues with their own staff.
- The VMI project directly involved staff from the medicine directorate at RSH. This related to empowering staff and ensuring minimum waste in the organisation
- 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.. We saw staff members had been put forward for this award on some of the wards we visited.
- Ward 4 had introduced a "brilliance box" onto the ward. This gave staff the opportunity to highlight good practices they observed on the ward. The winner of the month would be rewarded.
- In early 2016, staff on three hospital wards at RSH took part in a multidisciplinary accelerated discharge event (MADE) to help patients who no longer need to be cared for at the hospital be discharged earlier.

Innovation, improvement and sustainability

- 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 didn't 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 had in place a "buddy partnership" with St George's Hospital in London, to improve the experience of cancer patients. The trust launched the partnership following the National Cancer Patient Experience Survey in 2014. The partnership allowed staff to share areas of good practice and innovation, leading to service improvements, which, in turn, aimed to enhance the cancer patient experience. In March 2016 the trust recruited the first UK patient into a study called RECEPROS. This looked at the effectiveness of an investigational drug compared to placebo in Ulcerative Colitis. Ulcerative Colitis is a long-term condition, where the colon and rectum become inflamed.
- The trust was the highest recruiters into the Mammo-50 interventional study. This study aimed to establish if patients aged 50 years or above could be identified as to who required less frequent mammographic surveillance, whilst investigating alternative methods of follow-up.
- The trust were supporting the 100,000 Genomes Project. One of the main aims included setting up a sustainable genomic medicine service to bring benefit to patients, with cancer and rare diseases.

Surgery

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

Information about the service

Royal Shrewsbury Hospital provides adult inpatient and day surgery services for specialisms including trauma orthopaedic, vascular, urology, colorectal and ophthalmology.

Between October 2015 and November 2016 there were 72,724 emergency and elective admissions with 54,283 operations performed. The hospital has consistently struggled to meet the 18-week referral to treatment time (RTT) due to bed availability.

This was a focused inspection, following up our inspection that took place in October 2014. At that time the service was rated as requires improvement in safe, effective, caring and well led and inadequate in responsive.

We inspected the pre-admission clinic, theatres and the recovery area. We also inspected four wards and the day surgery unit.

We spoke with 29 staff, 14 patients and their relatives and carers. We observed patient care and reviewed nine medical records.

Summary of findings

We rated surgery as requires improvement because there were concerns about safety, responsiveness and leadership. There were three Never Events relating to retained products following surgery, current safety thermometer information was not displayed on the wards and we found a range of issues with equipment and infection control. Inconsistencies were identified in the staffs application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist. Compliance with mandatory training rates was variable. Nursing staff vacancies were impacting on continuity of care and an acuity tool was not used to assess staffing requirements.

Agency staff competencies were not always monitored or assessed and there was no structured competency framework for nursing staff working in specialisms. The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015.

Staff were confused by the management of the surgical services and felt they were not included in future plans for surgery. Managers felt they had a lot of responsibility with little authority. Staff said they were listened to but action was not always taken.

However, we also saw that staff were caring and compassionate, they were aware of their role in duty of

Surgery

candour and had a good understanding of the Mental Capacity Act 2005. They were also aware of how to report a safeguarding and what to look for when caring for patients.

The service was effective, the National 'bowel cancer audit' performance was recorded as 100% in 2016, VTE assessments were completed in line with national guidance, length of stay was below the England average and we saw robust multidisciplinary team working throughout surgery.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- There were three Never Events relating to retained products following surgery. However, we saw that a full investigation had taken place with an action plan and wider learning.
- Current safety thermometer information was not displayed on the wards.
- Theatre storerooms did not have a cleaning schedule and required work to repair the ceiling to maintain cleanliness and prevent infection, although we saw this had been addressed when we visited unannounced.
- Equipment in theatre was in need of repair or replacement, although we saw this had been addressed when we visited unannounced.
- Medication refrigerators temperatures were not recorded daily on the wards.
- Patient medical records were not secure in all areas.
- We found that not all recovery nurses or operating department staff were trained to ALS level. Attempts were made to ensure that a ALS trained member of staff was available on each shift. To mitigate the risk we observed that the anaesthetist did remain in theatres whilst the patient was in recovery.
- Inconsistencies were observed in the staffs application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist, we saw that not all elements of the checklist were verbalised and not all members of the team were included.
- A staffing establishment tool was in place but a patient acuity tool was not used to assess the staffing numbers required for the dependency of the patients.
- Nursing staff vacancies were impacting on continuity of care for the patients.
- Ward staff were unsure of their part in responding to a major incident in their area.

However:

- There was a positive approach to reporting incidents, staff received feedback and there was evidence of wider learning.

- Staff were aware of their role in Duty of Candour when things went wrong and we saw examples of where it had been applied.
- Wards were clean and tidy and staff complied with infection control polices.
- Staff were aware of how to report a safeguarding and what to look for when caring for patients.
- Patient records were maintained to a good standard.
- Venous Thromboembolism (VTE) assessments were completed in line with national guidance.
- There was no evidence to support agency staff competencies were monitored or assessed to ensure they were safe to work on the wards.

Incidents

- There were three 'never events' reported between January and October 2016. Two related to retained products following dental surgery in January and August and a third related to a retained catheter in October 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We looked as the root cause analysis for the events that demonstrated a full investigation, action taken and wider trust learning. One investigation was complete and two were ongoing.
- In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SI's) between October 2015 and September 2016. The most common type of incidents reported were surgical or invasive procedures (eight incidents - 50%).
- All staff had access to the electronic incident reporting system in ward areas and theatres. Positive reporting was encouraged to promote patient safety. We were told that written feedback was given to the reporter with verbal feedback when necessary. Staff told us they were not made aware of incidents occurring in other areas of the hospital or at the other site, to enable them to share learning.
- NHS England published National Safety Standards for Invasive Procedures (NatSSIPs) in 2015, based on national learning from harm, near misses and never events. One member of the theatre staff had further developed these standards to enhance safety procedures in theatres. Within theatres at RSH, 'Lockdown' had been introduced using Local Safety Standards for Invasive Procedures (LocSSIPs), whereby an incident, which was not reportable as a serious incident, could be logged, reviewed, action taken and therefore avoiding it happening again.
- During October 2016 there had been 71 local exception reports logged for review using this approach. For example, issues such as staff shortage, staff behaviour, planning issues and admissions, which affected the department, had been raised. We were told that a full time position had been requested to manage this patient safety role as there was evidence of a small change in practice which had already prevented non-compliance with VTE prophylaxis.
- Mortality and Morbidity reviews were discussed at quarterly meetings. Senior staff, involved in the case for discussion, were encouraged to attend.

Duty of Candour

- Staff we spoke with were aware of duty of candour (DoC) and the need to be open and honest with patients when things go wrong. 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.
- We met and spoke with a patient who had received a duty of candour letter from the trust relating to a surgical error. We saw examples of DoC letters, which were compassionately written and gave full explanations of the event and apologies were offered for the experience at the trust. We saw DoC information displayed on staff room notice boards.

Safety thermometer

- The NHS Safety Thermometer was in use by the surgical directorate to record the prevalence of patient harms in the ward environment. This entailed monthly audits of the prevalence of avoidable harms such as pressure ulcers, venous thromboembolism (VTE), falls and catheter-related urinary tract infections. This provides immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

- We saw that up to date information was not displayed on the ward notice boards; for example either October 2016 data was on display (previous month) or no date or data was displayed on all notice boards.
- The surgical assessment unit (ward 33) displayed quality improvement data relating to patient safety, clinical effectiveness and patient experience for September 2016.
- Staff we spoke with on the wards did not demonstrate robust knowledge of the safety thermometer data, including the reason for this being collected, displayed and their individual ward performance.
- We requested safety thermometer data following the inspection that was forwarded to us on a trust wide basis. Specific ward data was not available.

Cleanliness, infection control and hygiene

- Most ward areas we visited were visibly clean and tidy. Plaster damage to the walls was identified in patient bays, side rooms, entrance to most wards and hospital corridors. Paper notices were seen stuck to theatre walls and blood was visible on the doorframe to theatre 10.
- Throughout the inspection, we saw domestic staff carrying out their specific cleaning duties. We saw signed cleaning schedules in patient bathroom and toilet facilities.
- In ward 22 we identified disposable curtains without date of replacement written on them and the staff were unsure of the timescale in which they were to be replaced. This was also found and made as a recommendation by the trust infection control team following the 'Quality Ward Walks' taken place between July and September 2016.
- In theatres, we evidenced the storerooms had not been deep cleaned; there was no cleaning schedule available to support this. We saw that the ceiling in both equipment and theatre pack storerooms had ceiling tiles missing or broken, this had been reported to the estates department, added to the risk register, but no action had been taken. This meant that ceiling matter might fall on the equipment, which was subsequently used in theatre. This ceiling had been repaired when we returned for the unannounced inspection although watermarks were still evident.
- There were no cases of **Methicillin-resistant Staphylococcus aureus** (**MRSA**) or Clostridium difficile (CDiff) infections reported between October 2015 and September 2016.
- Ward staff we observed complied with the key trust policies e.g. arms bare below the elbow, hand hygiene, personal protective equipment and isolation of infected patients.
- In theatre five, we observed staff not following the arms bare below the elbow policy; an anaesthetist was wearing a long sleeved shirt and a wristwatch. We also observed a clinician entering theatre wearing a watch and no facemask. Other staff were observed with arms bare below the elbow.
- We saw that not all patient venflons had a 'date and time' sticker applied to ensure they were managed in line with the cannulation policy.
- Data for Surveillance of Surgical Infections (SSI) in **NHS** hospitals in England is collected to monitor infection rates post-surgery. Between July 2016 and September 2016, 122 large bowel operations were performed with 12 inpatient infections reported and one infection on readmission. Forty-nine vascular procedures were carried out and 91 neck of femur repairs with both categories reporting one infection on readmission.
- Patient-led assessments of the care environment (PLACE 2016) had been reported. The assessments give patients and the public a voice that can be heard in any discussion about local standards of care, in the drive to give people more influence over the way their local health and care services are run. Cleanliness for the trust scored 99.6% slightly above the England average of 98.1%.

Environment and equipment

- In theatres, we found some equipment in need of replacement.
- Lights bulbs were taped in to the theatre light fitting; theatre operating lights replacement programme was added to the risk register in April 2013 and reviewed in October 2016 with no action taken.
- Rust was found on two trolleys, theatre stool wheels, a bowl stand and a pneumatic tourniquet trolley. Doorframes were damaged on the theatre exits and plaster scrapes on the walls were evident.
- Theatre equipment issues were logged and raised by one member of the theatre staff; they were not allowed specified time on the duty roster to carry out this role which meant that on occasions equipment was delayed in getting repaired or replaced.

- In theatres, resuscitation equipment was checked and found to be in order in all areas. Not all checks were signed for each day as per trust policy. For example December 12 missed (theatre eight location) and December 10 missed (Labcaire location).
- On the wards we found resuscitation trolleys in order with checklists dated daily for the month of December; previous months records were not available.
- Two blood pressure machines had been on order two weeks for orthopaedics and there was no date for delivery given. This meant staff had to wait to use the equipment that was available.
- An oxygen cylinder was found unsecure, free standing on ward 22. Cylinders should be secured upright with a chain or strap in a cylinder cart to avoid combustion when knocked over.
- Bariatric equipment could be organised for the wards on the same day or next day when required.
- In the patient-led assessments of the care environment (PLACE 2016), facilities at the trust scored 91%; slightly lower than the England average of 93%.
- The ambiance of ward 22 was very warm (sited above the hospital boiler room); staff told us they did ask for the situation to be rectified to aid patient comfort and promote a suitable environment for recovery.
- In the ambulatory care clinic, we saw patients nursed in the small three-trolley bay. There was no suction or oxygen in this area, portable oxygen and suction were available and mobile call bells were used. We were told that patients had stayed in this area for up to two days with trolleys replaced with beds and risk assessments completed.

Medicines

- We saw that medicines were not stored and administered in a safe way.
- One incident, which had required a full RCA was later downgraded, based on low level of harm. The vast majority of medication errors resulted in low harm or no harm and the ward managers managed these locally.
- On the orthopaedic ward (22), we found a faulty keypad lock on the medication room door; this had been reported the previous day. A medication audit completed in September 2016 scored 28%. The manager told us that treatment room cupboards were found unlocked, staff were not wearing tabards during medication round, refrigerators were found unlocked and one patient's medicine locker was found unlocked. An action plan had been written and a re-audit was planned. The manger told us an incident form was raised since the audit to highlight that the controlled drugs cupboard was too small for the ward stock; yet no action had been taken.
- Refrigerator temperatures had not been checked and recorded daily on all wards; on ward 22 we found 14 recordings were absent for November 2016 however, those temperatures recorded were within acceptable limits. When questioned, ward staff we spoke with were unsure of the acceptable temperature range required.
- In theatres, we heard that one operation was cancelled due to absence of a required drug. No controlled drug errors were reported. A pharmacy technician supported the department five days a week. We saw intravenous fluids were stored off the floor, in a locked storeroom.
- We saw nurses check patients' identification bands prior to the administration of medication, including checks for any allergies.
- Controlled drugs were seen to be stored, checked and administered appropriately in all areas.
- Take home medication for discharged patients was mainly arranged during the patient board round, the day prior to their discharge. This action ensured patients were not delayed leaving the ward and their bed became available at the earliest opportunity.
- We met and spoke with an onsite pharmacy medicines information manager. They told us that the technicians supported each ward and were available for support and guidance for the ward and medical staff. There were currently no safety issues relating to surgery. Medicines safety pharmacist held safe medicines group meetings and minutes were distributed to each ward through the intranet.
- We reviewed the RCA following a medication error in oncology that demonstrated a full investigation, action taken and wider trust learning.

Records

- In all areas we inspected we saw patients medical notes unsecure. We saw notes trolleys left open and unattended by ward entrances, patient notes left unattended in unlocked offices and patient notes left on reception desks attended by the public. Patient note trolleys were not lockable.
- At the unannounced inspection, we again saw patient notes left unsecure; two full notes trolleys were left unattended and open on a ward corridor, near to the

nurses' station. There were no nurses at the station for several minutes at a time. Pressure area assessment forms, with patient details completed, were left unattended on the top of the nurses' station, ready for assessments to be completed.

- Nursing care records were stored in the patient bay. These showed evidence that patient risk assessments were completed on admission to the ward. For example, we saw that falls, mobility and nutrition were documented.
- Patients were linked to an electronic system known as VitalPac, which alerted medical staff when their observations were out of their normal range. Staff on the ward showed how the data was collected on a hand held device which quickly identified signs of patient deterioration and automatically summon timely and appropriate help.
- Fluid and food charts were in place for some patients and were seen completed appropriately.
- Pre-operative assessments took place in the pre-assessment clinic and we saw that the individual information was checked on the day of surgery.
- In January 2016, results were presented at the surgical governance meeting for the 50 surgical case notes audited in September 2015. Of these, 86% held a completed drug chart and 88% held a discharge summary. An operation form and consent form was present for 93% and 86% had a pre-operative checklist completed. The audit showed 89% of entries were dated, 45% were timed and 71% signed. Recommendations included training and education during induction week, senior review of medical notes during and after ward rounds, team awareness of their responsibility for record keeping; to ensure notes were present prior to seeing patient and a bigger sample size and more regular auditing for more reliable results. The case notes we reviewed during the inspection were neat and tidy with entries signed and dated.

Safeguarding

- Staff we spoke with were aware of how to report safeguarding concerns and what to look for when caring for patients.
- Five referrals had been raised towards the trust and six referrals instigated by the trust for RSH between October 2015 and September 2016.
- Between November 2015 and December 2016 the training completion rate for adult safeguarding Level 2 was 64% and adult safeguarding Level 3 was 75%.The trust target level was 100%.

Mandatory training

- Mandatory training was delivered though specific training days, e-learning and trust wide training days. Staff told us they discussed their training needs during their appraisals. The trust target for training compliance was 100%.
- Mandatory training which included manual handling, fire safety, basic life support, information governance and infection control was completed annually.
- Training records showed a wide variance between wards and departments in completion rate however, we were told that this was due to department and wards attending training at various times throughout the year and the planned projections for attendance were on target to achieve100% compliance by the end of the year.
- For example at the time of the inspection, nursing staff completion rates ranged between surgical assessment unit 57%, preoperative assessment 69% and theatre recovery 71%. The wards completion rate ranged between 83% and 92%.
- Medical staff mandatory training rates also showed a wide variance in the completion rate with trauma and orthopaedics recorded as 14%, urology recorded as 33%, Gastroenterology 71%, colorectal 67% and anaesthetists 67%.

Assessing and responding to patient risk

- We found some inconsistencies in the theatre staff's application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist in the five sessions we observed. Not all stages were carried out correctly or recorded, as the procedure stipulates. For example, a silent focus was not observed, as a radio played loudly in the background of the theatre and not all persons were present for the introductions.
- Whilst observing, we saw that the checklist was not fully completed on all occasions including being unable to hear the 'time out' session again due to the same radio which continued to play loud music. Not all elements of the checklist were verbalised and not all team members

were included, for example whilst they connected a diathermy lead. The checklist was not recorded electronically despite a fully editable theatre software system being in place

- The WHO checklist was retrospectively audited using patient records, showing high levels of compliance; but this did not include any 'actual' observational audits of the process. For example, the May 2016 audit score was 100% for 217 patients and in July 2016, audit score was also 100% for 219 patients audited.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) state that at all times there should always be at least one member of staff present who is Advanced Life Support (ALS) trained. An anaesthetist should always be available to attend immediately; who will provide further ALS trained 'cover' for emergencies in the recovery area. However, the anaesthetist does not require being physically present at all times. At the hospital, we found that not all recovery nurses or operating department staff were trained to ALS level. Attempts were made to ensure that a ALS trained member of staff was available on each shift. To mitigate the risk we observed that the anaesthetist did remain in theatres whilst the patient was in recovery.
- Theatre staff visually and verbally confirmed swab and instrument count between practitioners in line with Association for Perioperative Practice (AFPP) recommendations for safe practice 2016. This, with patient information, was recorded on a white board as per the AFPP best practice guidelines.
- AAGBI discharge criteria was followed for example all discharged, day surgery patients received verbal and written instructions and were warned of any symptoms that they may experience. These instructions were given in the presence of the responsible person who was to escort and care for the patient at home.
- In the endoscopy unit, the WHO checklist was observed fully and found to be carried out and recorded correctly.
- Confidential Enquiry into Patient Outcome and Death (CEPOD) classification, describes the need for immediate, urgent, expedited or elective surgery. One CEPOD specific theatre was staffed 24 hours a day, seven days a week for immediate life, limb or organ-saving intervention including the intervention for acute onset or clinical deterioration of potentially life-threatening conditions.
- Modified Early Warning Score (MEWS) alerted clinical staff to any vital signs that fell out of safe parameters for the patient's normal scores. This information was then alerted to the senior medical staff to attend to the deteriorating patient. MEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to surgical ward patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- We were told that the medical staff were responsive to their specific ward, however less responsive when on call due to workload pressures. Medical outliers did have a link medic to support each ward, which had improved the management of them away from their speciality ward. For example the need to prescribe specific medication or discuss discharge arrangements.
- Bay safe nursing had been introduced on to the wards whereby when necessary due to patient needs bays were never left unattended by a member of staff.
- VTE assessments were performed and recorded for patients preoperatively, in line with national guidance.

Nursing staffing

- A staffing establishment tool was in place but an acuity tool was not used to assess the required staffing numbers for the dependency of the patients on each ward. Planned and actual numbers of staff were displayed on the wards but not always for the correct day. We were told that the staffing numbers had not been assessed for a long time and no assessment of patient dependency was considered initially.
- The current skill mix aimed for that where possible the senior sister on the ward was supported by grade 5 and grade 6 staff nurses. The senior sister was supernumerary; however, we were told that most days they worked with the patients to support the staff which meant that their supernumerary responsibilities were overlooked.
- We reviewed rotas and found that planned staffing levels were maintained most of the time with a heavy reliance on bank and agency staff.
- Agency and bank staff use was reported as high due to staff vacancies and levels of staff sickness. Approximately seven permanent staff nurse vacancies were reported on each ward; the surgical assessment unit had 10 staff nurse vacancies. Absence of staff was covered by block booked, regular bank or agency staff where possible.

Surgery

- We were told that the induction processes for bank and agency staff was variable. We heard that some temporary staff received more support than others due to time constraints on arrival to the ward.
- We asked the ward manager about agency staff competencies and how they were assured the staff on their ward was safe. We received no assurance that this was monitored or assessed.
- Nursing staff handovers occurred at the commencement of each shift with office and bedside discussions taking place in the patient bays.
- Staffing levels were displayed showing that all theatres were staffed in line with AFPP recommendations for safe staffing.

Surgical staffing

- Medical staff attended the ward seven days a week and daily consultant ward rounds took place.
- Medical handovers took place at the commencement of each shift and after 'on call' shifts.
- High use of locum medical staff was reported which was being reviewed by the trust. Staff told us they regularly saw the same locums, which did assist with continuity for the staff and patients.
- Patients admitted as an emergency were seen daily by consultants. The inpatient wards were covered by a separate registrar and Foundation Year 1 who would call the consultant as necessary, which we were told at time felt to be too onerous for a junior doctor, especially when relatively junior registrar was on duty who was not familiar with the patients.

Major incident awareness and training

- In November 2016, 42 senior managers attended a table top exercise to test the sites major incident plans. The theatre manager told us they had attended.
- Staff told us they could not remember attending any major incident training but they were aware that there was a plan on the intranet. Nursing staff on the wards were not aware of how they would be included in a major incident or the action to take. Theatre staff were aware of their need to react should a major incident happen and how lists would be cancelled and the recovery area cleared.

Are surgery services effective?

Good

We rated effective as good because:

- Care and treatment was planned and delivered against evidence based policies and procedures.
- 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%.
- Patient Reporting Outcomes Measures (PROMS) were better than the England average.
- Patients were satisfied that their pain control had been well managed
- There was robust multidisciplinary team working throughout surgery
- There was a good understanding of the Mental Capacity Act 2005 amongst the staff.
- Patient nutrition and hydration needs were met.

However:

- There was no structured competency framework for nursing staff working in surgical specialisms to ensure they had the right skills.
- Not all staff had an appraisal but plans were in place to deliver by the end of year.
- The perioperative surgical assessment rate did not meet the national standard.
- In the 2015 National Emergency Laparotomy Audit, the trust achieved a green rating for two measures, an amber rating for five measures, and a red rating for three measures.

Evidence-based care and treatment

- Local evidence based policies and procedures were available on the intranet for staff to access current care and management information.
- We saw minutes of Centre Operational Governance meetings where new or updates to national and local guidelines were discussed.
- Staff followed local policies in relation to the management and observation of patients before, during and after surgery in line with NICE guidance CG50, the acutely ill patients in hospital.

- Care pathways ensured that best practice was followed. For example, management of fractured neck of femur and sepsis.
- The bariatric specialist nurse followed National Bariatric Surgery Register (NBSR) guidelines to ensure that individual patient experience was managed and the effectiveness of weight-loss surgery discussed.
- In theatre, we observed staff following post-anaesthesia care unit (PACU) handover checklist. After general, epidural or spinal 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.

Pain relief

- Patients we spoke with on the wards were satisfied that their pain control had been well managed and sufficient. We saw pain levels were scored and monitored during individual comfort rounds.
- Patient's post-operative pain relief options were discussed at the pre op assessment.
- The acute pain team at the trust provided support and advice in the management of acute (severe) pain for adult inpatients during their hospital stay. They delivered assessable pain management and provided specialist support, care and advice.

Nutrition and hydration

- We saw a trolley available on each ward for patients to provide themselves with drinks throughout the day. We also saw healthcare assistants conduct comfort rounds and provide patients with food and drinks.
- Meals were served during protected visiting times. Those patients who required assistance were seen to be supported. Food and fluid balance charts were completed for those patients that required observation due to their condition.
- We saw that full fat milk and extra menu additions were available on the orthopaedic ward to aid recovery and bone repair. Nutritional assessments were completed to assess individual patient dietary needs were recognised and met.
- Intravenous fluids were prescribed and administered when diet and fluids were restricted.
- Referral to a trust dietician was arranged when concerns relating to a medical condition, malnutrition or dietary intake were identified.
- The bariatric service had a dedicated mental health dietician who offered a two-year follow up service.

Patient outcomes

- Patient Reporting Outcomes Measures (PROMS) for Royal Shrewsbury Hospital from April 2015 to March 2016 indicated that 88% of patients who had undergone groin hernia repair reported improvement following the procedure, which was better than the England average of 82%. Patients reporting worsening of symptoms following surgery were 12%, which was better than the England average of 18%.
- Following varicose vein surgery, 86% of patients reported improvement, which was better than the England average of 84%. Patients reporting worsening of symptoms were 14%, which was better than the England average of 16%.
- National 'bowel cancer audit' performance was recorded as 100% in 2016. A clinical nurse specialist saw 98% of patients, which was better than the national average of 92%.
- The proportion of patients not developing pressure ulcers was 99%, which falls in the best 25% of trusts.
- The average length of stay was 15 days, which falls in the best 25% of all trusts.
- In the 2015 National Emergency Laparotomy Audit (NELA), the trust achieved a green rating (>70%) for two measures, an amber rating (50-69%) for five measures, and a red rating (<49%) for three measures. The final case ascertainment rate was rated as red. The rating represents a score of between 80-100%. In the 2014 NELA, 10 of 28 services were found to be available and 3 were available on request. There were 293 emergency laparotomies performed.
- Between March 2015 and February 2016, patients had a lower than expected risk of readmission for non-elective admissions and a higher than expected risk for elective admissions. The elective specialty upper gastrointestinal surgery had the largest relative risk of readmission.
- The perioperative surgical assessment rate was 64.7% across the trust which does not meet the national standard of 100%.

- In the 2016 hip fracture audit for Royal Shrewsbury Hospital, risk-adjusted 30-day mortality rate was 9.67, which is higher than expected.
- The proportion of patients having surgery on the day of or day after admission was 71.5%, which does not meet the national standard of 85%. The perioperative surgical assessment rate was 96%, which does not meet the national standard of 100%.

Competent staff

- Identified scrub practitioners were trained Surgical First Assistants (SFAs) and staff confirmed that only those appropriately qualified would act in this role. Scrub practitioners performed dual role duties only for minor procedures in line with Perioperative Care Collaboration 2012 recommendations.
- We were told that all agency staff received a full theatre department induction prior to working a shift.
- Staff received annual appraisals by the ward manager where their performance and professional development was discussed. Current appraisals scores were recorded as day surgery 94%, endoscopy 85%, pre assessment 94%, theatre recovery 100%, orthopaedics 44%, urology 94% and short stay 81%. We were given assurances that trust target of 95% was on target to be achieved. Consultants we spoke with individually and as part of focus groups told us that they received appraisals, which was required as part of their professional revalidation.
- Nursing staff told us they undertook competency programmes for skills such as medicines management and venous cannulation.
- No structured competency framework was in place for nursing staff working in specialisms such as urology, vascular surgery, gastroenterology or colorectal surgery. Post operatively these patients may present with a higher level of dependency and increased skills to care for their needs may be necessary.

Multidisciplinary working

- There was evidence of robust multidisciplinary team working throughout surgery.
- Staff told us that there was a good understanding of each other's role and responsibilities and this was shown respect by all.
- Physiotherapists and occupational therapists attended the wards daily and contributed to the daily board round patient review. Dieticians, speech and language therapists and social workers all attended patient reviews as necessary.
- External multidisciplinary team working included transfers between sites and service level agreements with local hospitals such as Robert Jones Agnes Hunt Hospital in Oswestry for specialist advice and guidance.

Seven-day services

- Availability of 24-hour consultant led care was in place and we were told worked effectively. Staff told us they had no hesitation to contact the senior medical staff should the need arise and they felt well supported by the current on-call arrangements
- Physiotherapy ran a six-day service with no ward presence on a Sunday. We were told that orthopaedic patients admitted over the weekend would be seen by the on-call team of physiotherapists if required.
- Occupational therapy service ran a weekday service only.
- Availability of out of hours imaging, pharmacy and physiotherapy were organised on a bleep system for overnight and weekend support.

Access to information

- The trust had introduced electronic boards to most wards, called 'patient status at a glance' (PSAG). These boards allowed staff to see each patient's individual information and basic care requirements by use of symbols. Patient names were visible to anyone at the nurse's station and this privacy issue was raised with the staff.
- We were told that patient records and test results were easily accessible. However, the VitalPac electronic system did on very few occasions fail and the staff reverted to paper records when necessary.
- Medical records were requested by the ward clerks and delivered to the wards. Patient records were paper based with nursing and medical notes recorded in separate folders.
- Staff showed us how they had access to current policies and procedures via the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- Patients told us they were asked by staff to give permission to attend to their needs.
- We saw consent forms signed and dated prior to surgical procedures being carried out.
- Staff had a good knowledge of Mental Capacity Act 2005 and the process to follow. They told us they had attended training. MCA assessments took place on the wards when necessary involving the patients family where possible and their responsible social worker.

Are surgery services caring?

Good

We rated caring as good because:

- Patients we spoke with told us their ward experience had been positive and that the staff were friendly and helpful.
- Staff were seen attending promptly to call bells.
- Patients in theatre recovery were greeted on arrival and told who would be looking after them.
- Clinical nurse specialists were available for advice, guidance, and on-ward training.

Compassionate care

- The Friends and Family Test response rate for surgery at Royal Shrewsbury Hospital was 13% from September 2015 to August 2016. The percentages of respondents that would recommend the service were consistently above 85%, during this period where figures were available. The only exception was Ward 22 at Royal Shrewsbury, which scored 82% in September 2015.
- Patients we spoke with told us their ward experience had been positive and that the staff were friendly and helpful.
- We observed staff attend promptly to call bells and address issues within an acceptable timescale. For example, walking a patient to the toilet and administering analgesia.
- We saw staff asking for permission to enter an area where privacy curtains were being used protecting the patient's privacy and dignity.
- Patients in recovery were greeted on arrival; we observed them being reassured that the operation was over and they were told who would be looking after them.

Understanding and involvement of patients and those close to them

- We spoke with several patients who had undergone surgery. Each was aware of the procedure that had been completed; they were aware of their post-operative plan and potential discharge date.
- Patients we spoke with were fully aware of their planned care and possible discharge date. All the patients we spoke told us they were aware of what was happening to them; they told us they felt involved with their care.
- In preadmission clinic, patient's surgery was explained to them, including the post-operative plan of care and expected length of stay. Patients told us they were given opportunities to ask questions and seek clarification.
- Patients told us they felt safe and the nursing and medical staff had alleviated any of their fears.
- Patient's relatives told us they felt informed about their relatives care, although on most occasions they did have to ask staff rather than be told. One relative we spoke with told us they thought the staff were very busy but they make time to speak with the patients and relatives to ensure they understood their care.
- One patient on the urology ward informed us that they remained in hospital due to a surgical error. An explanation by the hospital management had been offered to involve them in the plan of care and to give them an understanding but the patient had chosen not to receive it as yet. The patient was supported to return home on alternate days whilst they awaited corrective surgery.

Emotional support

- Clinical nurse specialists were available for orthopaedic, urology and vascular care. Staff were able to contact them for advice and guidance for patients and training.
- Discussions relating to anxiety and depression were discussed on admission. The staff we spoke with told us they contacted the consultant when a patient showed extreme anxiety prior to surgery to ensure they met with the patient prior to the surgery. The staff told us they gave the patient time to discuss their concerns and answered their questions to allay their fears. Patients we spoke with told us that the staff were very good at reducing their pre-operative nerves.
- Counselling services were arranged when necessary through the consultant referral process or as an outpatient.

Surgery

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015.
- Staff told us they would know if there were a complaint made on their ward but did not get to hear about other wards complaints, which meant that wider learning was not promoted
- We did not see literature on how to make a complaint around the wards for patients and their relatives to keep informed

However:

- The average length of stay was better than the England average
- Patients received reliable and responsive pre-operative assessments to ensure they were prepared for surgery
- Bariatric equipment was readily available when ordered for specific patients.
- The Butterfly Scheme was in place to discreetly identify patients with dementia or confusion with the use of a butterfly symbol

Service planning and delivery to meet the needs of local people

- Between April 2015 and March 2016, the average length of stay for surgical elective patients at trust was 2.8 days, compared to 3.3 days for the England average.
- For surgical non-elective patients, the average length of stay was 4.5 days, compared to 5.1 for the England average.
- For the same period, the average length of stay for surgical elective patients at Royal Shrewsbury Hospital was 3.3 days, equal to the England average. For surgical non-elective patients, the average length of stay was 4.4 days.
- The pre-assessment department prepared patients for their operation by recording the necessary information to ensure they were medically fit prior to undergoing surgery. Patients were booked to attend the department two to three weeks before the operation date to discuss their individual needs and to meet with the consultant again if required.
- To meet the needs of patients there were arrangements in place with a local private hospital to provide support for the surgery service. At the time of the inspection this hospital had provided treatment for eight patients in the previous two weeks. The agreement covered provision for the private hospital to conduct procedures for up to 50 patients covering the two months following the inspection.

Access and flow

- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015. Data provided showed the trust average was 76%, whereas the England average was 80%. This showed that the trust was not meeting the 90% treatment indicator.
- 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.
- "Matron of the day" had been introduced, whereby a designated matron took on the role of lead for site meetings and worked with the capacity manager arranging patient bed moves and patient discharges. Meetings took place three times a day where data was collected to identify the escalation level and identifying the hospital beds available.
- Admission processes varied depending on the type of planned surgery with day surgery patients admitted in the day unit and brought to the theatre on a trolley.
- Short stay surgical patients were admitted and sat in chairs then walked to theatre, as no bed was identified in the hospital. Male and female patients sat within the same waiting area in theatre gowns and dressing gowns.

Should a bed not be available during that day, the patient was fully recovered in recovery area, including receiving a sandwich and tea before attending the ward to be discharged. Staff told us they felt it unsuitable for patients to witness other patients returning from theatre and on some occasions emergency situations; remaining in this area, to be fully recovered, did not follow the principles of the department, which was a recovery area only. We were told that no patients stayed in recovery overnight.

- 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%.
- Due to shortages of beds in other areas of the hospital staff told us at times medical patients were admitted to the surgical wards.
- NHS England data showed that for the period July 2015 to July 2016 the trust cancelled 1163 surgeries. Of these, 0.9% were not treated within 28 days.
- Discharge arrangements followed the trusts policy and procedure. Patients left the hospital with a discharge letter, take home tablets and advice sheets. Where possible relatives escorted patients home or transport was arranged. Staff told us that day surgery patients were regularly asked to leave their bed prematurely, so that a new day case patient may use the bed.

Meeting people's individual needs

- We were shown a reliable and responsive pre-operative assessment tool that had been developed in house by a clinical nurse manager, an anaesthetist and an IT expert. Used to pathway patients and ensure they were look after from pre operation to post operation according to their risk. Their records were labelled as red, amber or green, pre-empting the appropriate levels of care required whilst in hospital. The care plans were then individualised to the patient to ensure their needs were met during their stay.
- We heard that bariatric equipment was readily available and the staff experienced no delay in receiving beds, chairs and moving equipment when ordered for specific patients.
- Translation services were accessible using the direct dial number displayed on the ward.
- The 'patient passport' is a personal information document to avoid repetitive questioning for relatives and carers Staff told us the passport supported patients with dementia and any form of learning disabilities, We did not see any in place during the inspection.
- A local inpatient audit for August 2016 showed improvements in several areas from the previous audit including: Patients who did not share a bathroom with patients of the opposite sex, patients who were not bothered by noise at night from hospital staff, patients who reported doctors did not talk in front of them as if they were not there
- The Butterfly Scheme was in place to discreetly identify patients with dementia or confusion with the use of a butterfly symbol on their bed. The "carer's passport" was also used; encouraging carers to visit and stay with patients living with dementia providing reassurance, support, and help with eating and drinking and other day-to-day activities.
- Patient-Led Assessments of the Care Environment (PLACE) 2016 reported dementia friendly score as 58% for the trust below the England average score of 75%.
- Staff told us there was a Swan scheme in place for patients who were receiving end of life care and to support their relatives through this difficult time.

Learning from complaints and concerns

- Staff told us they would know if there were a complaint made on their ward but did not get to hear about other wards complaints, which meant that wider learning was not promoted.
- We did not see how to make a complaint literature around the wards for patients and their relatives to keep informed.
- 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 contactfor 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.
- Between October 2015 and November 2016, 54 complaints were received for surgery at RSH. We were told that no complaints were currently outstanding for surgery at this site.

Are surgery services well-led?

Surgery

Requires improvement

We rated well-led as requires improvement because:

- Staff were confused by the management arrangements of the surgical services including the recent ward moves and the bed configurations
- We heard that the estates team were slow to respond to repair requests; ward areas waited what they thought to be an unreasonable time for repairs such as faulty call bells
- Managers felt they had a lot of responsibility with little authority for example having to ask directors to book agency staff felt undermining and time wasting
- Staff felt listened to when issues were raised but were less positive about the action taken
- Staff felt they were not included in future plans for surgery

However:

- Staff were committed and worked hard to deliver patient care.
- Staff felt supported by local leaders.
- Each ward had a buddy executive who was tasked to meet the ward manager and staff and discuss any issues.
- Patients and local people were encouraged to get involved in the hospital. Volunteers from the local community worked alongside staff in different departments assisting staff and patients.

Leadership of service

- Surgical services were part of the Scheduled Care Group. The group included outpatients, surgery, oncology & haematology, cancer services, head, neck & ophthalmology, MSK and anaesthetics, theatres & critical care. Each speciality, or centre, had a clinical director, centre manager and matron. The Care Group was led in a triumvirate by an assistant chief operating officer, head of nursing and care group medical director.
- Staff told they felt supported by the local leadership when there was a problem but were unsure if the senior leaders understood the day-to-day pressures.
- We were told each ward had a buddy executive who some wards had seen and others not. The buddy role was tasked with meeting the ward manager and staff to discuss any issues on the ward and to support them in getting action taken.
- One manager told they felt they had a lot of responsibility with little authority for example having to ask directors to book agency staff felt undermining and time wasting.

Vision and strategy for this service

- Staff were aware of the trust values, understanding their role in consistently providing safe care where possible. Staff told us they were empowered to raise concerns; however, issues such as staff shortage, ward environment improvements and some training issues were not addressed. Harm free care days were not displayed; we were told that when mistakes did happen the staff understood the importance of being open and honest. Staff told us they were less sure on the vision due to the reconfiguration plans that were being discussed.
- The current configuration of the specialities between two site was under discussion, reviewing sustainability in an attempt to provide the best service for the local communities.
- We spoke with a number of staff who told us they were confused by the management arrangements of the surgical services including the recent ward moves and the bed configurations. Staffing shortages and use of agency staff caused frustration with permanent staff having little or no support. The future for the service was described uncertain by many staff due to many changes and lack of insight in to the day-to-day issues and poor information update from management.

Governance, risk management and quality measurement

- The responsibility for the management, control, and funding of a particular surgical risk lay within the care group or centre concerned. The care group had a mechanism for signing off all medium and high risks. Risks were acknowledged and signed off by directors, when scoring 15 or over. Higher risk scores 20 plus were signed off by the chief operating officer. The risk was then forwarded with a risk reduction plan to the operational risk group (ORG). ORG discussed the risk and agreed the risk scoring taking account of all known

factors. At each meeting of the ORG the validated risks scoring 15 or above were prioritised. The list was presented at each meeting with new risks introduced and the ranking of other risks reviewed. Where there was more than one risk such as staffing these were grouped together to show an increased impact.

- First priority on the surgery risk register focussed on loss of accreditation status with failure to maintain Joint Accreditation Group (JAG) standards due to the inability to recruit a nurse endoscopist. Attendance at statutory and mandatory training was also on the risk register; a new venue for training and a programme review planned to increase compliance.
- Staff we spoke with were unsure about the risks register within surgery; staffing shortages and the use of agency staff was their personal priority
- Quality and safety issues were discussed at centre operational governance meetings. Health care standards were also discussed at these meetings such as referral to treatment targets and cancellation of operations.
- The quality and safety committee was chaired by a non-executive director and included two further non-executive directors. The board of directors and executive level director groups received monthly performance reports on national and local targets.
- We heard that the estates team were slow to respond to repair requests; ward areas waited what they thought to be an unreasonable time for repairs such as faulty call bells.

Culture within the service

- We heard that there were many good people working within surgery, for the right reason, the patient. We heard that staffing shortages and management pressure could lead to staff behaviours changing due to anxiety and stress. Staff told us at times their efforts did not feel valued.
- Staff told us they had attended a duty of candour meeting describing the requirements of staff and mangers to be open and honest when things went wrong an imbedded culture at the trust.
- Staff told us that they felt the staff were tired but dedicated to make sure patients were safe and well cared for even though times on the ward were extremely busy and occasionally staff breaks were missed.

Public engagement

- The Patient Experience and Involvement Panel (PEIPs) brought together patients and carers to shape the plans for improving patient experience; improving the way the hospital gathered information about patient experience and to gain feedback directly from patients.
- If patients or visitors had a particular interest in hospital services, or if they had shared their experiences, good or bad, the management encouraged them to contact the hospital to join appropriate initiatives and expert patient groups. This information was available on the hospital website.
- Patients and local people were encouraged to get involved in the hospital by becoming a member of the trust. The elected public governors had a powerful voice to represent the interests of communities in Shropshire, Telford & Wrekin and mid Wales. Members of the public could apply by visiting the 'Becoming a member' page on the hospital website.
- Trust wide approximately 800 volunteers gave their time to patients, visitors and relatives at both hospitals playing an important role working alongside staff in a variety of different departments.

Staff engagement

- Staff told us that 'Staff Update' shared information with the staff, working across both sites. Available as a paper version and on the intranet it updated staff on recent events and plans.
- Staff felt listened to when issues were raised but were less positive about the action taken. For example, staff shortages and pressure to discharge patients to avoid cancelling new patient's surgery.
- Staff felt they were not included in future plans for surgery and their opinion was not sought.

Innovation, improvement and sustainability

- The medical director sent out a 'Message of the Week' to all staff describing events of the week and asking staff to reflect on their experiences.
- In April 2016, 33 managers across surgical services attended a 'managing budgets' masterclass to help them understand financial terminology and financial statements. The class encouraged them to make better business decisions from evaluating financial data and manage the politics of budget setting and negotiation. Key performance indicators (KPIs) and management of staff sickness were also discussed.

Surgery

- In June 2016, 32 Band 6 staff nurses from across surgical services, attended a professional development masterclass which explained their future role and the trust expectations of them. We did not speak with anyone who had attended.
- Sustainability of the service was under discussion with future plans for site amalgamation being considered.

Maternity and gynaecology

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

Information about the service

The Shrewsbury midwifery led unit (MLU) is attached to the main building of the Royal Shrewsbury hospital. The unit has two labour rooms, plus a pool birth room, and 13 beds for antenatal and postnatal care. Shared toilet and shower facilities were available for women during their stay.

This inspection was a focused follow up from the 2014 inspection. We rated this service as good overall.

We observed that the unit offers a friendly atmosphere with an emphasis on natural birth. The MLU admits women who have been assessed as low risk and suitable to deliver their baby there, as there are no medical facilities such as doctors, consultants or operating theatres. Admissions to the unit between 01 November 2015 and 31 October 2016 were 277, there were 157 births at the unit and 356 women were transferred from the consultant led unit at Princess Royal for post-natal care for the same period. Should complications arise, women who book and attend to deliver their baby in the Shrewsbury MLU would be transferred to the consultant led unit at Princess Royal Hospital, 18.5 miles away.

The MLU also offers postnatal care for women who have delivered at the consultant led-unit at the Princess Royal Hospital (PRH) following a caesarean section or when they needed extra support such as with breastfeeding. The average length of stay for women is two to three days following delivery but can vary depending on the woman's needs. Women told us they did not feel rushed or under pressure to go home.

We did not specifically inspect the community midwifery service during this inspection. The midwives on the unit worked as a team with the community midwives including rotation onto the community and community midwives working in the MLU. At the start of the inspection, there were three women and three babies present in the unit. During the morning, another woman was admitted in labour and delivered, making a total of four woman and four babies. We spoke with five members of staff –three midwives, a women's service assistant (WSA) and the lead midwife. We spoke with three women and we reviewed four sets of women's notes.

Maternity and gynaecology

Summary of findings

Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate. The service was responsive to the requirements of women from the booking-in clinic and at all stages of their journey. There was a range of choices for women during labour. Women told us they felt involved with decisions in their care.

We saw that staff followed good practice with infection prevention and control. Staff were aware of how to report incidents and were encouraged to do so. We saw that staff had opportunities to learn from incidents across the service. Staff had access to and followed policies and procedures that were based on national guidance.

We saw a positive culture within the MLU with strong leadership.

Effective systems of communication were established between the consultant led unit and the MLU, ensuring that effective care and treatment could be delivered.

A full review of the maternity service was ongoing, looking at different ways to improve the service, staff were clear about their role and levels of accountability.

However, the maternity specific safety thermometer was not being used to measure compliance with safe quality care. Staff completion of some topics included in the mandatory training programme was lower than the trust target of 100%. There was no signage on the store room door containing portable Entonox to inform people that compressed gases were stored there. Woman's notes were not always available when women arrived at the MLU in labour.

Are maternity and gynaecology services safe?

Good

We rated safe as good because:

- Staff understood their responsibility to report incidents and concerns.
- Systems were in place to minimise the likelihood of infection and we observed that Shrewsbury midwifery led unit (MLU) appeared visibly clean in all areas we inspected.
- Medicines were managed safely; controlled drugs were checked and signed as correct at the beginning of each shift.
- All staff had received safeguarding training and there were systems in place to ensure prompt referrals for any safeguarding concerns.
- Formal handovers took place at the beginning and end of each 12 hour shift. Staff discussed women's care and reviewed care plans during this time.

However:

- The trust chose not to use the maternity specific safety thermometer to measure compliance with safe quality care.
- Portable Entonox gas containers were stored in a store room ready for use by community midwives. This store room door did not have a sign to inform that compressed gases were stored there.
- Woman's notes were not always available when woman arrived at the MLU in labour and we noted omissions in two of the four sets of notes we reviewed.

Incidents

- Staff told us they were aware of how to report incidents and that they did so when appropriate. Staff reported incidents through the trust's electronic process and the lead midwife provided feedback following investigation and reporting. Staff showed us how they could request feedback by ticking the electronic form. Staff told us they usually received feedback from incidents they had raised in relation to the MLU and were given the opportunity to discuss the outcome of incident investigations at bi-monthly staff feedback meetings with the lead midwife.

- Between 1 November 2015 and 31 October 2016 the MLU reported 216 incidents. Of these, one was categorised as a serious incident, there were no incidents categorised as severe or moderate harm and 32 minor harm.
- Maternal transfers are not recorded as an incident by the trust. They informed us this was because there is no NRLS code to support this type of incident. However, there were 117 women transferred to the consultant led unit between 1 November 2015 and 31 October 2016. If the service is not reporting all transfers as incidents an opportunity to learn from these events may be missed.
- The service produced a quality and safety report which was discussed at monthly governance meetings. Minutes from these meetings were shared across all the MLUs to promote cross unit learning. Learning from incidents were discussed at unit meetings, this included learning from incidents at other units.
- We saw a folder which was available for staff to read which reported incidents from all midwifery services within the trust which supported shared learning. The unit also received minutes from service level perinatal mortality meetings, copies were available on the unit.
- There was evidence of service developments resulting from incidents. For example, we saw where an incident investigation had triggered the introduction of new transport pods for the safe transport of new born babies. We saw one of these pods in place in the MLU.
- There were no 'never events' reported by the MLU between 01 November 2015 and 31 October 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Duty of Candour

- 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.
- Staff we spoke with described their obligations under duty of candour and were aware of when they would be required to act upon this. They had not participated in specific training that focussed on this but told us they had received information and could find further guidance.
- The lead midwife told us about a complaint which had met the requirements of duty of candour. She explained how this had resulted in a visit to the family home to apologise and explain what action had been taken as a result of their complaint. Following this feedback was given to staff and lessons were learned.

Maternity Safety thermometer

- The Royal College of Obstetricians and Gynaecologists (RCOG) launched the maternity safety thermometer in October 2014. The maternity safety thermometer measures harm from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological wellbeing.
- The trust did not utilise the maternity-specific survey. The head of midwifery told us they were aware of the maternity specific thermometer but that they felt that the service collected the same information elsewhere. We reviewed data that the trust collected and found that the trust collected some data via the maternity dashboard however, they did not collect and review harm in relation to postpartum haemorrhage, separation of mother and baby and psychological wellbeing.
- The service submitted data to the national NHS Safety Thermometer patient care survey instead. This measures harm from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism.

Cleanliness, infection control and hygiene

- We observed that Shrewsbury MLU appeared visibly clean in all areas we inspected and appropriate equipment was in place such as foot-operated bins. We saw cleaning logs and records completed to confirm that equipment was cleaned regularly.
- We observed all staff complying with the trust's infection control policy. We saw staff regularly washed their hands and used hand gel. Staff adhered to the hospital's arms 'bare below the elbow' policy. The October 2016 hand hygiene audit report showed Shrewsbury MLU to be 100% compliant.

- There had been no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia between 01 November 2015 and 31 October 2016.
- We reviewed the birth pool and found this to be well maintained. During the inspection, we saw staff cleaning the birth pool, which had recently been used. The staff member explained how staff cleaned the pool after each use, using specifically designed cleaning products. They showed us the pool cleaning record staff had completed. Staff took water samples from the pool, and ran the water system twice per week as per the Legionella policy. Staff used thermometers for water temperature testing prior to women entering the pool and a thermometer remained in the pool during use.
- Staff changed the curtains around beds regularly and we saw this documented for 16 October 2016 and 10 November 2016.
- There were food hygiene safety policies in place which staff adhered to in respect of food handling in the ward and kitchen areas. Food hygiene safety training was provided to staff. These were both under review at the time of the inspection.

Environment and equipment

- The staff told us that they had sufficient equipment to confirm the health and well-being of mothers and babies. We saw stickers on equipment to confirm that equipment had been regularly tested and serviced.
- Resuscitation equipment included an adult resuscitation trolley. We saw a record to confirm that this had been checked daily.
- A PANDA (emergency equipment that is used to resuscitate babies) was stored centrally and was plugged in and ready for use. This was checked regularly to ensure it would be safe and ready for use if required.
- To keep the area secure, a buzzer system was in place at the entrance to the unit. Visitors could only gain access via an intercom system.
- We saw that staff kept store cupboards locked and we found these to be clean and tidy.
- A new-born transfer 'pod' was stored on the ward. This was a transportable incubator-type appliance that was used to transport babies safely. We saw from records that staff checked and signed this daily.
- We saw records that staff checked and restocked the homebirth equipment carried by community midwives regularly. Community bags were currently part of an audit to standardise the equipment bag.
- We saw portable Entonox gas containers were stored in a store room ready for use by community midwives. This store room door did not have a sign to inform that compressed gases were stored there.
- Records confirmed that staff cleaned and checked foetal heart monitors and blood pressure cuffs after each use.
- We saw a 'Patient Environment Checklist' carried out monthly and a daily check of the environment carried out by staff.

Medicines

- We observed that all medication was stored safely on the unit.
- We looked at administration charts for four woman and saw that these had been completed as required. Woman we spoke with told us they received their medication on time.
- Patient Group Directives (PGD's) were in place on the unit. PGD's ensure patients receive safe and appropriate care and timely access to medicines, in line with legislation because midwives are specifically trained to give certain medications without the need to go to a doctor first. These medicines included analgesia (pain relief medication).
- To take out (TTO) medication was arranged on transfer, or prescriptions faxed from the consultant led unit.
- We observed staff check controlled drugs during the handover process, two midwives ensured the count was correct. Records confirmed this occurred twice a day.

Records

- Patient records (electronic and paper) were stored securely. Electronic records (on the computer) were only accessible by staff that had access to these. Paper records were stored in a locked cabinet accessible only to midwives with a key.
- Staff told us and women confirmed that all women were given pregnancy record folders that they retained and took to appointments throughout their pregnancy. Following the birth, these were returned to the woman's medical records.
- Woman sometimes arrived at the MLU without notes. We saw a woman arrive at the MLU in labour who went on to deliver a baby and a temporary set of notes was

pulled together by staff. According to the maternity dashboard the number of women booked without notes should range from 0 to 1. However from April to November 2016 each month had exceeded this with figures ranging from 1 to18.

- We reviewed four patient records and found them to hold relevant clinical information, which was legible, signed and dated. However, there were gaps in two women's records. For one woman, antenatal VTE assessments were not completed correctly and for another woman the section on allergies was not completed.
- Records contained risk assessments and relevant care plans. An audit of patient records involving all of the MLUs across the trust took place in July 2016. This included five records from Shrewsbury MLU. The results showed that there had been significant improvements in the way staff managed records since the previous audit in 2014. However, there were still areas of concerns and recommendations for improvement, for example medical staff must sign and include their GMC number (stamp) on records following patient treatment. The audit also highlighted a need to improve ante-natal record keeping and the trust had an on-going audit in place monitoring this.

Safeguarding

- The staff we spoke with told us they followed safeguarding maternity guidelines and had attended safeguarding training. Records showed 100% of staff at Shrewsbury MLU had completed Safeguarding Adults training and 77% of staff had completed Safeguarding Vulnerable Children to level 2 and 77% had completed Safeguarding Children to level 3.
- The midwifery safeguarding lead told us there were plans to increase the number of safeguarding children training hours to match the recently updated national recommendations.
- Staff we spoke with confidently described situations which would prompt a safeguarding concern and lead to a referral being made. Staff told us they would contact the lead midwife for safeguarding within the trust or if 'out of hours' the social worker would be contacted with a faxed referral completed following the telephone call.
- Staff gave women the opportunity to raise any concerns confidentially with the midwife and were offered a named midwife to provide continuity of care working within a multi-agency team.
- The named midwife for safeguarding and/or specialist Midwife for improving women's health provided advice and support to midwives caring for women with complex social issues.
- We saw safeguarding procedures had recently been followed in respect of a patient on the unit who had developed a sudden and severe mental health episode following delivery. Staff took timely action to ensure the safe care of mother, baby and other woman and babies in the unit. Under the Protection of Vulnerable Adults (POVA) scheme, the woman was referred to a specialist unit ensuring they received appropriate care and treatment in the right place at the right time.
- A new-born standard operating practice (SOP) was in place for review in May 2018. This stated that the new-born infant should be cared for in a secure environment to which access is restricted and a reliable baby security system enforced, to minimise both clinical and non-clinical risk issues for the most vulnerable. The baby tagging security system had been introduced at Shrewsbury MLU but was not working at the time of the inspection. Staff said, and we observed, that no one could get in or out of the building without staff opening the door with a code.
- Midwives were able to make referrals to support women with additional needs 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. There were safeguarding link midwives in all ward areas to support the safeguarding team and to increase midwife skills and competence in this area.
- There was a business case in progress for sourcing additional resource within the safeguarding team. The lead safeguarding midwife covered all children's safeguarding, domestic abuse and female genital mutilation referrals.
- Clinical areas displayed posters about forced marriage and domestic abuse, providing contact details for support agencies.

Mandatory training

- There was a maternity-specific mandatory training guideline, which included the training needs analysis for 2016-2019. This detailed what training was required for midwives, women's support assistants and medical staff and how often. There were 35 modules in total and included appropriate modules such as obstetric emergency multi-disciplinary skills drills, a fetal monitoring package, newborn life support skills, early recognition of the severely ill woman, post-operative recovery skills and neonatal stabilization. Compliance rates for all modules were provided at service level only and not broken down by unit. Electronic fetal monitoring was recorded at 80% and care of the severely ill women recorded as 95.8%. Neonatal stabilisation training was recorded as 82%. Newborn life support training was reported at 93%. The target was set at 80%.
- Care group governance meeting minutes for November 2016 showed that 84% of midwives, 74% of Women's Services Assistants (WSAs) and 86% of obstetric medical staff were up-to-date with obstetric emergency skills. The target was set at 80%.
- The statutory mandatory training programme included 16 topics such as patient moving and handling, adult basic life support, slips trips and falls and equality and diversity. At Shrewsbury MLU this was completed during a 'three day' annual mandatory training programme.
- Trust mandatory training completion target was 100%. At the time of the inspection, compliance with mandatory training at Shrewsbury MLU was reported as 73%.
- Compliance with basic life support training was 74%. Advance life support for adults was not mandatory for midwifery staff.
- The unit also carried out three live skills training sessions in June and July 2016.

Assessing and responding to patient risk

- At each antenatal appointment women's individual risks were reviewed and reassessed.
- The trust had a clear policy on antenatal clinical risk assessment, setting out a colour coded criteria for women who were suitable for low (green) risk care (delivered by community midwives and MLU births), those who were medium risk and required closer monitoring (amber) and those classed as high risk (red) and needed care under a consultant. Midwives were able to describe this policy and confirmed that risks were discussed with women at each stage of the process.
- A local survey of all women who gave birth at the trust during September 2016, asked what women were informed about when choosing where to have their baby. The survey showed that 91.7% of women were informed that MLUs were staffed solely by midwives, 97.3% were aware that if a problem arose during labour they may be transferred to the consultant unit and 82.9%, were aware of how long it would probably take to transfer from the MLU to the consultant unit.
- Risk assessments could change with each antenatal appointment. Finally, when a woman reached 36 weeks of pregnancy, a final decision on the place of delivery was made. Decisions were made involving the woman and the midwives at the MLU.
- For women who chose to deliver their baby at home against medical advice, two midwives would attend the entire labour to support and provide professional advice throughout. An on call system was in place for the time around the due date in order to facilitate this.
- At Shrewsbury MLU the Modified Early Obstetric Warning Score (MEOWS) and Newborn Early Warning Score (NnEWS) system were in place for women and babies. Staff recorded the MEWS and NnEWS to detect the need for early intervention or transfer of a woman or new born. We saw these were completed by staff.
- We observed a handover and saw that risks of in-patient's were discussed and time given for further questions or guidance to be provided.
- We saw the trust's perinatal sepsis guideline 'Sepsis related to the antenatal, intrapartum and postnatal period' due for review in September 2016. This included the nationally recognised 'Sepsis 6' care bundle and the maternity sepsis screening tool, in line with Sepsis Trust UK guidance.
- The baby's NnEWS score was recorded at the time of delivery. We were told that only if there were signs of the baby's deterioration would recording continue. A midwife showed us the process for escalating concerns about babies and staff were clear about the process to follow up, if there were concerns.
- A birthing pool evacuation policy was in place, including manual handling guidance for care of the women. Each woman was risk assessed to use the pool prior to being

included in the birthing plan. The staff practiced 'skills and drills' for the emergency removal of the women from the pool should their blood pressure drop or the delivery process change.

- There was a policy and procedure in place for escalation and safe transfer of patients where there were concerns.
- There were 117 women transferred to the consultant–led unit between 1 November 2015 and 31 October 2016. This included women who were transferred as a direct result of antenatal monitoring as well as women in established labour. The most common reasons for transfer were meconium stained liquor, delay in first stage and "other maternal reason".
- A service-wide review of transfers by ambulance to the CLU between April and September 2015 included 46 women transferred from RSH. The review concluded that women were not being unnecessarily transferred and outcomes for those who were transferred were good.
- Medical staff were supportive and available; scans and foetal measurements could be faxed to the consultant led unit for review and second opinions.
- The trust had a policy in place for the transfer of postnatal women from the consultant led unit to the MLU. The policy states that after an initial assessment following birth, women can be transferred if she and her baby meet the criteria. The criteria excludes women who were less than 24-hours post caesarean section and/or were not mobile and babies who had not fed in the first 12 hours, if they had neonatal jaundice that requires medical treatment, babies with a fetal abnormality, requiring nasogastric tube feeds or with a temperature of less than 36°C. There were 356 women transferred for post-natal care between 1 November 2015 and 31 October 2016.
- We saw where a woman had started her labour in the MLU, had developed complications of labour and had been transferred to the CLU where she had a caesarean section to deliver her baby. The following day she had been transferred back to the MLU to continue with her post-natal care. We saw in her records that medical staff on the CLU had examined the woman and had assessed her as fit for transfer to the MLU.
- The trust told us it does not currently audit the transfer of women from the consultant unit to the MLU as this is part of the planned process, however, they are planning an audit of handover of care between the CLU and the MLU during 2017/2018 as part of their audit programme.

Midwifery staffing

- The planned staffing levels for Shrewsbury MLU were a minimum of two midwives on the unit during the day and one through the night with another midwife on call. There was one Women's Support Assistant (WSA) on duty 24-hours per day seven days per week to support the midwives. Staffing levels were displayed on the unit and we saw that the MLU was continually staffed with the required staffing levels. Data provided by the trust showed that during October and November 2016, there was only one occasion where these levels were not achieved during the day, at night these levels were consistently achieved during the same period.
- The trust monitored occasions that midwives were moved from the MLU to cover on the consultant led unit. We saw where a 'database ward escalation sheet' had been completed by the senior midwife on duty on these occasions and that staffing levels on the MLU had remained appropriate to meet the needs of women in the unit at the time.
- The unit did not use agency midwives. Where there were staffing shortages, cover was arranged internally through extra shifts for permanent staff or bank staff.
- Staff told us that women received one-to-one care in labour and there were always two midwives present at delivery. We saw this at the time of the inspection when two deliveries took place.
- Formal handovers took place at the beginning and end of each 12-hour shift. During this, staff discussed each woman and reviewed care.
- When a home birth was planned, there were two midwives on call. These were planned for on the staff duty rota.
- A booking-in clinic, held on the unit, was staffed with one midwife three days per week between 8.30 and 16.30.
- At Shrewsbury MLU, there were no staff vacancies and there was no staff on long-term sick leave at the time of the inspection.

Medical staffing

- There were no medical staff working at the unit. If midwives had concerns about a woman or baby they would seek guidance over the telephone from the labour ward at the Princess Royal Hospital. We saw records of this in a woman's notes prior to her transfer to

the consultant-led unit and the woman told us that she was pleased with how quickly she had been transferred to the consultant led unit when she was in labour and complications had arisen.
- Midwives told us that the medical support was very responsive at all times, including out of hours.

Major incident awareness and training

- Maternity services in Shrewsbury MLU were linked in with, and part of, the major incident awareness and training for the Royal Shrewsbury Hospital.
- The trust had a major incident and business continuity plan should the need arise.
- There was a lone worker policy for community midwives which protected the staff and ensured they sought support when needed.
- Staff discussed trust guidelines and policy updates during staff meetings including future models of care. We saw that eight out of ten policies had been reviewed and updated.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line the current evidence based guidelines. Staff adhered to the trust Intrapartum Care on a MLU or Homebirth policy (June 2016), all trust wide policies and procedures were available to staff on the intranet.
- Effective systems of communication were established between the consultant led unit and the midwifery led unit (MLU), ensuring that effective care and treatment could be delivered.
- Pain relief was discussed with women and administered in line with their birth plan where possible.
- There was an effective approach to supporting staff; continual professional development and learning opportunities were promoted.
- Verbal consent was gained between the mother and midwife during examinations and the recording of observations.

However :

- The Supervisory team were few in numbers due to recent resignations and some of the remaining supervisory group had two caseloads, 1: 15 is recommended for support and professional guidance some supervisors had double that number.

Evidence-based care and treatment

- In line with National Institute for Health and Care Excellence (NICE) Intrapartum Care Guidelines (2014), staff adhered to the trust Intrapartum Care on a MLU or Homebirth policy (June 2016). This ensured medium and low risk women, who chose to give birth at home or in a MLU, received safe, evidenced-based care.
- In line with National Institute for Health and Care Excellence (NICE) Quality Standard 22, antenatal care included screening tests for complications of pregnancy and the antenatal care of all pregnant women up to 42weeks of pregnancy. This included primary, community and hospital-based care.
- A risk and needs assessment including obstetric, medical and social history was carried out, to ensure that woman had a flexible plan of care adapted to her own particular requirements for antenatal care in line with Royal College of Obstetricians and Gynaecologists 2008 guidelines (RCOG 2008).
- Effective systems of communication were established, between all team members and each discipline, as well as with the women and their families and were in line with RCOG 2008.
- The service audited compliance against NICE guidance on an annual basis.
- Trust wide policies and procedures were available on the intranet with key documents printed off as required.
- Guideline meetings were held monthly by the lead midwife. New guidelines were reviewed to ensure they reflected current practice; staff discussed these at maternity feedback meetings.

Pain relief

- Women we spoke with confirmed that their pain had been well managed and in line with their requests. One woman we spoke with told us she had received pain relief medication when she had requested this and the other woman said she had not needed any. We observed a midwife asking women if they required any pain relief medication during a drug round.
- We saw that pain relief was recorded and signed in women's notes. A variety of pain relief sources was

available to women including tablets, injections and gases such as Entonox. Women were able to use the birthing pool for pain relief if they wished to do this. One of the midwives told us, "Some women prefer to use the pool to relive their pain but they don't wish to deliver in the pool, and this is fine".
- Staff told us that they discussed pain relief with women and this was administered in line with their birth plan where possible.

Nutrition and hydration

- The women we spoke with were satisfied that they had received adequate meals and hydration. The women commented positively on the good quality and variety of the meals on offer.
- There was a wide choice of meals and staff catered for special diets. There was access to drinks at all times (woman could prepare their own drinks in the patient kitchen) and we saw that staff prepared hot drinks regularly for woman by the staff.
- The MLU was accredited with the UNICEF Baby Friendly Initiative (BFI). We saw that the unit promoted breastfeeding and the important health benefits of this for mother and baby. We saw information posters available and staff told us they discussed this with mothers at all stages of pregnancy and post-delivery of the baby.
- The unit was able to invite new mothers to attend the unit for breastfeeding support and if they chose to, could stay overnight to have continued support throughout the night hours.

Patient outcomes

- In 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030, with a 20% reduction by 2020. The trust had recently 'signed up to safety' to contribute to the NHS England ambition to improve maternity outcomes.
- The midwife to birth ratio for the trust from April to November 2016 was 1:30 and was in line with the recommended target of 'Birth-rate Plus'. The data provided was trust-wide and not broken down by unit. We were unable to determine the midwife to birth ratio for the MLUs.
- The trust-wide percentage of women having their babies at home across the trust was 1.3% as of November 2016 and this was the percentage for 2015/16 overall. This was just below the national England average for home births of around 2%.
- Maternal smoking status at the time of delivery data showed that the trust had a rate of 16% from April to November 2016 and 15% for 2015/16, which was better than the locally agreed target of 20%.
- The national target for booking appointments was 12 weeks and this was being achieved consistently.
- A trust wide audit was conducted involving 43 mothers who were interviewed about the breastfeeding support they had received while under their care. Questions included the support provided by staff at birth, learning about breastfeeding, food and fluids provided other than breastmilk, relationship building between mother and baby and antenatal care. The results showed that for most of the areas the trust achieved above 90%; mothers stated they had received adequate support. The percentage of babies provided with supplements to breastmilk should be below 20% however the trust had supplemented 24%.The score for mother's being shown how to hand express breast milk only just passed with a score of 81%.
- During 2016, the service introduced a maternity dashboard that identified key performance indicators and patients outcomes benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard.
- Shrewsbury MLU demonstrated 100% normal delivery between April 2016 and November 2016 which was better than the local target of 85%.
- Data showed that during the same time period 0% of women required manual removal of a retained placenta which was much better than the expected range of 0% - 2%.
- Rates of third or fourth degree tears were 0% which was much better than the expected range of 0 -5%.
- Zero still births were reported for this unit during April to November 2016.

Competent staff

- The service has a policy and procedure in place that set out the process for rotation of midwives in order to assist in supporting staff to gain experience in key areas of Midwifery and to refresh skills. A list of those rotating is produced every April and October.

- Midwives were rotated from the MLU, we met a midwife who had just returned from working in the consultant-led unit and she told us how much she had enjoyed her experience there and it had helped to update her skills. The service undertook a survey of midwives in May 2016, of the 213 respondents across all areas, 70% of midwives said they thought their clinical practice was enhanced.
- The trust provided us post inspection with evidence of newly developed midwifery competencies for all employed midwives. This was to commence in February 2017 and we saw the agenda for this programme. This included the importance of midwifery competencies, accountability, implementation and monitoring of these competencies.
- A preceptorship package was in place for newly qualified midwives, which included a specific structured rotational programme every three months. The rotation process ensured that the newly qualified midwifery workforce developed their skills and provided flexibility with service provision.
- There was a structured induction programme for new members of staff to work through. All new staff were required to complete an induction booklet, which was signed off by the ward manager.
- Current midwifery staff appraisal rate for the Shrewsbury midwifery team was 72% against a trust target of 100%.
- The purpose of Supervisor of Midwives is to protect women and babies by actively promoting safe standards of midwifery practice. Supervision is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The supervisory team were few in numbers due to recent resignations and some of the remaining Supervisory group had two caseloads, 1: 15 is recommended for support and professional guidance some supervisors had double that number.
- The MLU manager supported continual professional development and learning opportunities and midwives said they felt supported with their training needs.
- Forthcoming training sessions were clearly displayed for midwives to view and we saw several names of midwives wishing to attend sessions written down against the dates. These sessions included, 'Obstetric Critical Care Symposium for midwives', a 'Water birth Study Day' and 'Practical Obstetric Multiprofessional Training'.
- Midwives told us they received clinical supervision. Arrangements of new plans for clinical supervision were in the discussion stage along with the supervisor of midwives changing role.

Multidisciplinary working

- The staff described robust multidisciplinary working that was effective. Good communication and links with local GP's ensured the women had the support they required when discharged. Staff reported good working relationships with the consultant-led unit.
- The maternity service promoted multidisciplinary team working, including antenatal services. Community midwives, health visitors and social services staff promoted joint working.
- Service level agreements were in place for transfers between Shrewsbury MLU and the consultant-led unit at the Princess Royal Hospital.
- Daily communication with the community maternity team ensured staff maintained good working relationships between all the staff.
- A manager commented that this was "the best place I have worked for good multidisciplinary working". They said "The support we get from medical staff when we need them is great".

Seven-day services

- The MLU was open 24 hours per day, seven days per week.
- An on call system was in place to ensure that for women reaching the second stage of labour during the night, a second midwife would attend for the delivery of the baby.

Access to information

- The trust record management system ensured that staff had the appropriate access to relevant notes to assist them with care of the women and their babies.
- We saw that there was trust guidance available for staff on the intranet. This system was accessible and staff were able to show us where to find policies and protocols as well as trust wide updates.
- There was a folder available on the unit with information of meeting minutes and notices which identified the latest good practice and any updates to policies and procedures issued throughout the service and trust where appropriate.

- We saw newsletters from the Staffordshire, Shropshire and Black Country New-born and Maternity network. The newsletters provided updates and information for midwifery services across these areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that staff explained and requested consent from women at the booking-in clinic. Staff explained that they would ask women for their consent regularly for various procedures, such as the Combined Screening Test, and before examinations. Staff told us they provided as much information as possible before gaining consent.
- We observed that verbal consent was gained between the woman and midwife before and during examinations and the recording of observations. The women we spoke with during the inspection confirmed this.
- From the four records we reviewed, we saw that consent was appropriately recorded.
- Staff showed good awareness of the procedure to follow regarding the Mental Capacity Act.
- 75% of staff at Shrewsbury MLU had received mental capacity training as opposed to a trust target of 85%.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Results of the NHS friends and family survey showed that the proportion of women who would recommend the service was better than the England average.
- Women told us that they felt very well cared for and the staff were caring, thoughtful and compassionate
- We were told that women were monitored for their wellbeing at all stages of pregnancy and following the birth. Assessments for anxiety and depression were completed throughout their care.
- When necessary, counselling services were arranged through discussion with the women, the GP and the midwife to provide emotional support where needed.

Compassionate care

- The trust participated in the NHS Friends and Family survey. 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.
- During the same time, the results for women who had used the trust maternity service to give birth showed 100% would recommend it. The results for women who had received postnatal care were 99%.
- At the time of the inspection we observed staff interacting with women in a caring and compassionate manner, asking how they were feeling, if they were in any pain and if they needed anything.
- Women we spoke with at the time of the inspection told us that they felt very well cared for and the staff were caring, thoughtful and compassionate. Comments included, “I would give the care here a gold star rating”.
- The staff on the ward had received many thank you cards and letters of appreciation. .

Understanding and involvement of patients and those close to them

- Women on the ward told us they had been fully involved with their care plan and felt very well supported by all the unit staff. We saw women’s wishes were documented and they had signed in agreement with their care plan.
- We were told that the partners were also encouraged to be involved during the delivery and following the birth and we saw partners coming and going at the time of the inspection.
- We heard from women that staff offered additional support when required and they were encouraged to contact the unit with any queries. We also heard midwives talking to woman over the telephone giving them advice and reassurance about their pregnancy.

Emotional support

- Staff told us and we saw that women were monitored for their wellbeing at all stages of the pregnancy and following the birth.
- We saw staff monitored woman for anxiety and depression from the booking in clinic and throughout their care. We observed a midwife explore with a woman about how she was feeling when she appeared low in mood at the booking in clinic. She explained that they would talk to her about this at her next visit and that she could be referred to a specialist midwife for

help if she needed this. At 16 weeks post-delivery, the midwives discussed women's general feelings regarding mental health and assessed the need for further support.

- Midwives knew how to support women through puerperal psychotic episodes. They told us how they had supported a woman recently when she became mentally ill following delivery. Women on the unit who had been present at the time told us how staff not only supported the woman but also supported the other women on the unit at the time. A woman said, "The staff were marvellous and kept coming to reassure us".
- Staff liaised with the supervisor of midwives when they had concerns regarding the mental health or wellbeing of any women in the unit or the community,
- Bereavement counselling was available for staff to refer women to if they required following the loss of a baby. There was a Bereavement Midwife they could be referred to.
- When necessary, staff arranged counselling services through discussion with the women, the GP and the midwife.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Systems were in place to ensure the service was meeting the individual needs of women using the service. Staff assessed individual needs at the booking-in clinic and reviewed these throughout the woman's pregnancy.
- In the CQC Maternity survey 2015, the trust performed better than others for questions relating to patients feeling their length of stay in hospital was appropriate
- Staff were aware of the information women would require if they wanted to make a complaint and were clear of the procedure.

Service planning and delivery to meet the needs of local people

- The Midwifery-Led Unit (MLU) promoted a homely experience where staff made partners welcome and could access facilities as well as the women. Partners had open visiting to the unit.
- At Shrewsbury MLU between 01 November 2015 and 31 October 2016 there were 157 births. There were 277 admissions which included women who had chosen to give birth at the unit but were transferred to the consultant unit and those who chose to receive postnatal care at the unit.
- Ante-natal clinic appointments, held at the unit, were scheduled to meet the needs of the families; drop in sessions were promoted to reassure women if they felt reduced movements or wished to hear the foetal heartbeat.
- Staff arranged tours of the unit during the antenatal appointments for women and their birth partner. We saw staff showing prospective parents around the unit at the time of our inspection.

Access and flow

- Women could access the maternity services for antenatal care via their GP or by contacting the community midwives directly.
- Women were able to receive care at the unit if staff assessed them as low risk and/or if they opted for support following the birth of their baby.
- The unit cared for approximately 100 women per year who have given birth under a consultant elsewhere. Staff offered these women postnatal care in the unit.
- In the CQC Maternity survey, 2015 the trust performed better than others for patients feeling their length of stay in hospital was appropriate.
- Admissions in to the unit were planned following the initial risk assessment at the first booking appointment. Re-admissions were booked through the consultant led unit or the GP.
- Community midwives also re-admitted women when they identified that increased support would be beneficial to the women and new born.
- Women we spoke with were aware of when they were scheduled to be discharged to home. Woman reported they were happy that they were able to stay as long as they needed to and said it was "lovely not to feel pushed to go home". Staff issued discharge information to women with advice and guidance notes.
- Staff arranged post-natal follow up care as part of the discharge process with community midwives.

Maternity and gynaecology

Meeting people's individual needs

- We saw that the booking-in clinic presented an opportunity to assess womens' individual needs and requirements. This included screening for any physical and mental health conditions or symptoms. We saw that a woman who had come to book in with an unplanned pregnancy was low in mood and the midwife discussed her specific needs and family support with her. She explained that the woman would be monitored at each visit to ensure she received the right kind of care and support.
- Staff told us that women were supported to make choices about the place to give birth throughout their antenatal appointments. We saw a midwife showing a patient around the unit and explaining the use of the various facilities.
- There were specific risk factors in place, (such as a significant previous postpartum haemorrhage, multiple births and existing health conditions) which required consideration and would lead midwives to advise a hospital birth rather than a home birth or the MLU.
- There was a birthing pool available for women who chose to use it with different coloured lighting and the option and facilities to play music of their choice. A risk assessment was completed prior to use and if it was suitable for the women to use they would be cared for in the pool environment.
- Staff closely monitored the welfare of unborn babies to ensure they remained healthy throughout the pregnancy. For example, the midwife explained that the baby of a woman booking in at clinic would be closely monitored for diabetes as the woman's previous baby had been born with this condition.
- Woman were offered extra support where required under the 'Supporting Woman with Additional Needs' (SWAN) process. For example, staff could refer to a specialist midwife such as the Teenage Pregnancy Midwife or the Midwife for people with a Learning Disability, to ensure women received the right care and support throughout pregnancy, delivery and postnatal support.
- We saw at the booking-in clinic that staff provided leaflets containing information about pregnancy. This included an antenatal screening booklet about the 'Combined Screening Test' which is carried out (with consent) to screen woman and babies for any abnormalities. Staff can then identify any risk factors in order to manage these.
- Staff provided women with information about choices available to them during labour and delivery including the use of the birthing pool for pain relief only or pain relief and delivery.
- For women whose first language was not English, telephone translation services were available when required. In addition, conference calls and face-to-face appointments could be organised throughout the antenatal stage.
- There was a chaperone policy in place for women and information was contained in the leaflets and pregnancy record given to women.

Learning from complaints and concerns

- We saw that staff had access to the trust policy for complaints on the intranet and knew about the Patient Advice and Liaison Service (PALS), which supports patients with raising concerns. There were posters with this information displayed on the unit.
- Staff told us that they received very few complaints and that if any women raised a concern or issue whilst at the unit they would record these in the woman's notes, apologise, try to find resolution and escalate to the manager of the unit. The manager informed us that she would provide the information for women to make a formal complaint if they remained dissatisfied.
- No formal complaints had been received at the unit during the previous 12 months but when issues or concerns were raised the team discussed these at the MLU meetings to avoid them re-occurring.
- Information regarding how to complain, including posters, were visible on the unit and women we spoke with confirmed that they would talk to staff if they had any concerns.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- Staff demonstrated the values of the trust and they understood and were working towards the philosophy and vision of the MLU.
- There was a positive culture within the MLU with staff and women using the service encouraged to provide feedback into how improvements could be made.
- The service was focussed on women receiving good levels of care and support.
- Midwives were clear about their role and levels of accountability.
- Staff told us they felt informed by the managers and received appropriate feedback from meetings and through the intranet.
- A full review of the maternity service was ongoing, looking at different ways to improve the service with models of care being scoped by the trust.

Leadership of service

- The care group management team consisted of a care group director, a head of midwifery (HoM) and a care group medical director. The HoM and the care group director came to post in September 2016. There was a lead midwife for community services who was responsible for all MLUs within the trust. There was a manager at the unit responsible; for its day to day running, who reported to the lead midwife. Although these management arrangements were in place to ensure joined-up working, we saw that the unit mostly operated independently of the consultant led unit.
- Staff described local leadership as supportive and approachable. Midwives told us that they were confident that they were listened to but did feel nervous about the potential changes which may affect the future of the unit as a result of the ongoing maternity review.
- All staff told us they felt the lead midwife and unit manager kept them informed and up to date with feedback from service level meetings, and there were regular team meetings on the unit.
- Staff told us that the chief executive had visited the unit during the previous year and they had met the new head of midwifery.

Vision and strategy for this service

- We saw staff consistently delivered care and demonstrated behaviours in line with the trust vision and values which were "proud to care, make it happen, we value respect, together we achieve". Staff we spoke to on the unit could describe the trust values.
- Although some staff could not describe the future vision or strategy for maternity services , they were aware that the service was in the process of change. Staff were generally positive about the review and expressed hope that the personalised service they were able to offer at the MLU would not be compromised.

Governance, risk management and quality measurement

- There was a clear governance committee structure with direct reporting from the MLU to the care group leadership team.
- The care group governance committee received regular reports on quality performance, patient experience, serious incidents, complaints, audit and risk. These reports included information from the MLUs. We saw evidence of this in meeting records that were available for staff to receive updated information and feedback.
- Monthly ward meetings ensured that all staff were familiar with the trust's quality and safety issues and those relevant to the unit.
- The MLU did not have its own local risk register. All risks were recorded on the care group risk register, which was reviewed and updated monthly. We saw that the risk register identified and reflected the risks at MLUs such as IT system failures. Risks and responsible owners were appropriately assessed, reviewed and escalated.
- During 2016, the service introduced a maternity dashboard that identified key performance indicators and patients outcomes for each MLU, benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) maternity dashboard.
- During this inspection, we found that the trust were taking previous failures seriously and saw evidence of some changes taking place across all the MLUs. We saw that the service recognised they were in a transition period and that continued improvements were required. An external review of governance processes, was in progress at the time of our inspection. Senior managers told us this was because they recognised there was potential to make improvements.
- Staff at Shrewsbury MLU told us they received feedback in various ways. They described a supportive working relationship with their manager so could request feedback at any time but would also receive email

communication as well as information during meetings. We saw information displayed by the manager on the noticeboard and from across the trust in the "chatterbox" newsletter.
- Staff escalated quality issues to the head of midwifery through informal discussion and formally through the electronic reporting system.
- Midwives we spoke with were clear about their role and levels of accountability.

Culture within the service

- There was a strong emphasis on promoting safety and well-being of staff at Shrewsbury MLU. Staff were proud of the care they offered women and felt the service was very person-centred.
- Maternity staff spoke positively about managers of all levels in the service and told us they were visible and they felt well supported.
- Staff said they felt valued by leaders and each other and were part of a good team within the MLU.
- Woman we spoke with were very complimentary about the staff and spoke of a friendly and caring culture on the unit.
- Occupational health support was available for midwives and unit staff requiring emotional support.

Public engagement

- There was a quarterly maternity engagement group, which was a multi-agency meeting with a representative from the CCG, Healthwatch Shropshire, a supervisor of midwives, the HoM, the patient experience team and service users. We saw meeting minutes for September 2016 where patient experiences were shared and actions developed for areas of improvement.
- The service took part in the Maternity Friends and Family Test. Results for November 2016 showed that 98% of women would recommend the service against the England national average of 96%. Response rates were low with 41 women taking part. Results just or Shrewsbury MLU were not available.
- Thank you cards and letters had been sent directly to the staff on the MLU. Women referred to the 'professionalism, caring attitude and high standard of service received'. Women who lived locally told us that they hoped to deliver their babies at the MLU as it had a good reputation of having caring staff and a good safety record.

Staff engagement

- We saw a noticeboard was used to display lots of information about the maternity service and general information about the trust and upcoming events or changes to protocols.
- Staff told us their ideas were taken on board and they felt engaged with changes to the service and up to date with the progress of their suggestions.
- Staff at the unit had participated in the trust wide Midwifery survey, which had been used to gain views on how to move forward with the service.
- Monthly staff meetings took place where staff felt able to talk openly about any work related issues and could make suggestions or raise concerns. Staff felt that their line manager listened to them and acted on suggestions made.
- The Head of Midwifery for the trust had been to the unit and staff told us she was approachable. They felt they could raise issues through the management process or directly if appropriate. She also issued a monthly newsletter across the trust to keep staff up to date with maternity department information.
- Staff felt able to engage with their line managers at any time and said they felt able to go in to the manager's office and have a chat if they were free.

Innovation, improvement and sustainability

- The birthing pool at Shrewsbury MLU presented woman with an opportunity to have a water birth or just to relax in and use for pain relief during labour. The soft different coloured lighting system on the ceiling over the pool added to the experience.
- The sustainability of the MLU was being considered as part of the trust wide reorganisation.

End of life care

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

Information about the service

The trust had an end of life care (EoLC) team which consisted of the director of nursing and quality, an end of life care clinical lead, an end of life care facilitator and two nurses (job share) that were seconded into post for six months.

The trust also had a palliative care team who provided a service from Monday to Friday, from 9am until, 5pm. At weekends hospital staff could contact the local hospice for advice on the telephone. The palliative care team was made up of four nurses, two of whom were partly funded by the local hospice. Three of the palliative care nurses were based at the Royal Shrewsbury Hospital and one was based at the Princess Royal Hospital. The trust was in the process of interviewing for a palliative care doctor and funding had been agreed; palliative consultant support was being provided by the local hospice.

There were 1,607 deaths across both hospitals from April 2015 to March 2016. The palliative care team received 1190 referrals in the same period.

This was a focused inspection, following up our inspection that took place in October 2014. At that time, the service was rated as inadequate for safe and effective, good for caring and requires improvement for responsive and well led.

The mortuary department had recently undergone a major refurbishment. The newly opened Swan Bereavement Suite consisted of viewing rooms for adults and children, disabled facilities, an outside quiet area and designated parking spaces.

The Royal Shrewsbury hospital had a chaplaincy service and a multi-faith chapel on site for people who wished to pray; there was also a bereavement team on-site.

During the inspection, we spoke with staff from the end of life team and the palliative care team, mortuary staff and staff on the wards caring for patients receiving end of life care. We spoke with four patients, one family member and reviewed 20 patient records.

End of life care

Summary of findings

End of life care patients were not always asked where they wanted to be cared for in their last days. There was no specific data on how many people had died in their preferred location or how quick discharge took place in end of life care patients. Not all risks evident in EoLC were recorded on the trusts risk register.

Mortuary staff decontaminated surgical instruments manually; this exposed staff to unnecessary risk and did not provide a high level of disinfection. Infection prevention training was not part of mandatory training for mortuary staff and there were no arrangements for the regular deep cleaning of the mortuary environment.

Mental capacity documentation had not been completed for defined ceiling of treatment decisions when a person had been deemed as lacking capacity.

Staff from the palliative care and EoLC team were not up to date with mandatory training.

Staff were highly motivated and passionate in providing EoLC and there was a drive for change and improvement of EoLC services at the hospital. There was evidence of good working relationships across all areas of EoLC and staff felt supported by their immediate managers.

The trust had made EoLC one of its priorities in 2015/ 2016. Staff at all levels and from all departments understood the importance of a dignified death. There was evidence that learning around EoLC was being shared with staff within the trust.

The trust had rolled out the Swan scheme across the hospital, providing resources for staff and practical measures for patients and families, which included Swan boxes, bags and end of life information files for staff. A new bereavement suite and three Swan Rooms for end of life care patients were also part of the scheme at the Royal Shrewsbury Hospital. The mortuary department recently had a major refurbishment and was fit for purpose.

Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. The trust took part in the national end of life care audit. The trust had taken a number of actions in response to the audit. Staff from the palliative care team attended regular multidisciplinary team meetings in specialist areas.

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 care patient.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

- The mortuary department recently had a major refurbishment and was fit for purpose.
- Staff on the wards and the palliative care team were adhering to hospital policies on infection control and prevention. They washed their hands regularly and wore personal protective equipment.
- Hospital staff followed best practice guidance when administering controlled drugs.
- We found patient records contained relevant information, were legible, signed and dated.
- Staff knew whom to contact if they had any safeguarding concerns and could tell us the name of the safeguarding lead.
- Funding for a full time consultant in palliative medicine (with secretarial support) had recently been approved.
- There were processes in place for emergencies such as a pandemic, which mortuary leaders were aware of.

However:

- There were inconsistencies with medication records. We found two patient's charts where medical staff had not signed when medication dosages were changed.
- We were concerned about some of the infection control practices in the mortuary. There were no arrangements in place for regular deep cleaning, there was no specific audit programme in place to monitor the cleanliness of the mortuary, surgical instruments were decontaminated manually and infection prevention training was not part of mandatory training for staff.
- Staff from the palliative care and EoLC team were not up to date with mandatory training.
- In 12 "defined ceiling of treatment and allow natural death" we found a consultant had not endorsed two of the 12 forms and there were no formal reviews of the decision within the two patients' notes.

Incidents

- There were no never events or serious incidents reported by the End of Life Care (EoLC) service between October 2015 and September 2016. This may be because staff reported incidents under the speciality of which they occurred.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All staff we spoke with knew how to report incidents and were encouraged to do so. Staff reported incidents on the trust's electronic recording system.

Duty of Candour

- There had been no incidents in EoLC that met the criteria for duty of candour. 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.
- Staff we spoke with were aware of the principles of duty of candour such as being open and honest.

Cleanliness, infection control and hygiene

- We visited the mortuary department and saw that all areas were visibly clean and tidy.
- We noted that mortuary staff performed cleaning tasks after each post mortem. We reviewed several cleaning schedules and found them to be completed. However, there were no arrangements in place for the regular deep cleaning of the post-mortem room.
- Mortuary staff were 'arms bare below the elbow' and wore personal protective equipment (PPE), such as aprons and gloves. We saw there was a standard operating procedure (SOP) in place for PPE.
- The hospital's policy was that anatomical pathology technicians did not complete post mortems when they identified high-risk neurological airborne infections, such as tuberculosis (TB) or Creutzfeldt-Jakob disease (CJD). In such instances, the technicians would arrange to transfer the deceased to a specialist centre where the post mortem could then take place.

- There was missed opportunity to reduce infection control risks within the mortuary. We found that leaders in the mortuary did not complete hand hygiene or cleanliness audits.
- Mortuary staff decontaminated surgical instruments manually; this exposed staff to unnecessary risk and did not provide a high level of disinfection. Following our inspection the hospital arranged a visit from an infection control lead who recommended a washer disinfector to comply with HSE guidance.
- There were processes in place to record infection control risks when inputting details of the deceased onto the mortuary register. This was in line with the hospital's care after death policy. The mortuary register was a key record of deceased patients that staff logged into the mortuary. Staff were aware of the after death policy and could access the document in paper format or electronically.
- We saw there was a SOP in place for handling, storage and disposal of post mortem tissue.
- We reviewed training records and found that all (100%) staff from the palliative care team had completed their mandatory training on infection prevention. However, infection prevention training was not part of mandatory training for mortuary staff.

Environment and equipment

- The hospital's mortuary department had undergone a major £1.89 million refurbishment programme since our last inspection in 2014. We noted improved and increased fridge and bariatric capacity, robust systems to alert incorrect fridge temperatures, a separate visitor's entrance, and swipe card and security code access.
- We noted that mortuary staff kept a daily record of fridge temperatures; leaders tested and recorded fridge alarms on a weekly basis. Outside working hours, there were processes in place to ensure that switchboard staff were alerted if temperatures went outside the acceptable range. We saw that switchboard staff sent emails to senior staff and estates when fridge temperatures were not in range.
- There was a process in place for when mortuary equipment was in need of repair. Mortuary staff sent requests to the estates department electronically and kept a copy of the request in the department.
- We checked a range of equipment including syringe drivers and monitoring devices and found all had been serviced and tested for electrical safety.
- The hospital had syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication.
- Nurses told us that locating syringe drivers for people needing continuous pain relief had sometimes been difficult. We visited the medical device library and found that two syringe drivers were available, maintained and ready for use.
- We saw loan forms were in place to ensure the return of syringe drivers, which the EoLC team had recently reviewed.
- We reviewed the notes from the Shrewsbury and Telford Hospital EoLC Facilitator's 26 Month highlight report 2016. The report addressed the issues around a lack of syringe pumps and how the hospital had reviewed the process on returning loaned equipment. Staff in the medical device library told us that the situation had improved. The trust had purchased ten new pumps and staff could loan additional pumps from the hospice.
- We saw that porters used equipment to transfer the deceased from wards in a discreet manner. Porters assembled an X-Cube (three-dimensional expandable frame, with cover) over the beds of deceased patients to transport them to the mortuary.

Medicines

- Prescribing guidance for dying patients was available in the hospital's End of Life Care Plans and nursing staff knew where to find them. The plans were created to address the holistic needs of the dying person by providing supportive and compassionate person-centred care.
- The plans contained information to guide staff on anticipatory prescribing. Anticipatory medicines are a small supply of medications for patients to keep at home just in case they need them; they can only be administered by a doctor or a nurse. We saw the fast track checklist for EoLC patients listed four end of life care drugs to discharge patients home with.
- The palliative care team had developed a small information card on anticipatory prescribing in the dying patient. The cards were aimed at junior doctors and contained essential information, such as

symptoms, dosages and medication types. The cards contained additional information such as accessing out-of-hours nursing and medical advice from the hospice.
- There were inconsistencies with some medication records. We reviewed the medication records of seven patients and found that medical staff did not always sign patients' charts when medication dosages were changed. We found this to be the case in two out of the seven records we reviewed.
- We reviewed the controlled drug register on a ward that provided EoLC and found that two nursing staff had signed when administering controlled drugs to patients. All medications we checked were in date.

Records

- Staff told us they completed End of Life Plans in the last few hours and days of life. We saw that staff kept copies of the plans on the wards and knew where to find them.
- We found patients' records contained relevant information, were legible, signed, dated and mostly complete.
- The hospital had their own do not attempt cardiopulmonary resuscitation forms in place called "defined ceiling of treatment and allow natural death." We examined 20 sets of patient records of which 12 of these forms were in the records we looked at.
- We found a consultant had not endorsed two of the 12 forms and there were no formal reviews of the decision within the two patients' notes.
- We saw that the trust had carried out an audit of Defined Ceiling of Treatment and Allow Natural Death Policy in June 2016. The audit included both hospital sites (Royal Shrewsbury and Princess Royal Hospital).
- The audit identified 100% compliance with recording a defined ceiling of treatment decision on an approved form, good recording of patient details and the well-documented dates on decisions.
- However, the audit also found gaps in recording, a lack of evidence that the consultant had reviewed the original decision, and poorly documented discussions with the multidisciplinary team. The audit was due to be presented at the clinical governance executive meeting in January 2017.
- We saw that mortuary staff kept a record of the deceased in the mortuary register. Details included names, jewellery, tray numbers, if there were any infections and date of birth. Staff also kept a property book. We reviewed the mortuary register and the property book and found they corresponded.
- Mortuary staff recorded when a viewing of the deceased took place. Staff documented the bereaved details such as the time and date of the viewing, who was present and vehicle registration numbers.
- We reviewed mortuary records on organ tissue donation and found that staff had completed them appropriately.

Safeguarding

- Staff we spoke with knew who to contact if they had any safeguarding concerns and could tell us the name of the safeguarding lead.
- A safeguarding policy was in place, which staff could access via the internet. The policy included information about types of abuse, a safeguarding referral reform and a flow chart for staff to follow when reporting abuse.
- Not all staff were up to date with their safeguarding training. We reviewed training records of the EoLC and palliative care teams and found that three out of five staff were not up to date with their safeguarding training (level 2 adults and children).However, we noted the hospital had arranged safeguarding training for March 2017.
- Mortuary staff were not required to complete safeguarding training.

Mandatory training

- Palliative care, EoLC and mortuary staff had access to training sessions provided by the hospital. The palliative care team also had access to training provided by the hospice. Training was completed on line and face-to-face.
- We reviewed training records and found that not all palliative and EoLC staff had completed all their mandatory training, for example, 0% of staff had completed their conflict resolution training. The trusts target compliance rate for mandatory training was 100%. Mandatory training included subjects such as infection prevention, information governance and equality and diversity.
- Mandatory training for mortuary staff consisted of moving and handling, equality and diversity, and information governance modules. Two out of three (67%) of mortuary staff had completed all their mandatory training.

End of life care

- The trust did not classify EoLC training as mandatory at the time of our inspection.

Assessing and responding to patient risk

- The palliative care team provided a five-day service, Monday to Friday where ward staff could contact the team for advice on deteriorating patients. During out-of-hours and weekends, staff could contact the local hospice for advice.
- Nurses on the wards we spoke with were aware of the palliative care team's role and felt they were responsive to requests for support.
- The palliative care team lessened the impact of the lack of service over the weekends by anticipating the patients who needed support and putting plans in place. Staff from the palliative care team told us they would review the patient and complete a plan with the ward if they felt a patient would deteriorate over the weekend, and inform the hospice. We spoke with a sister on a ward that provided EoLC who confirmed this.
- Staff from the palliative care team told us that there was no set criteria when it came to reviewing patients, they aimed to review patients daily but would use professional judgement.
- Ward staff completed, monitored and reviewed risk assessment for patients receiving EoLC. For example, we saw risk assessments had been completed for nutrition, pressure damage and bed rails.
- We spoke with two patients receiving EoLC who told us that staff checked on them regularly and that they came quickly when they used their call bells.

Nursing staffing

- There were 3.8 whole time equivalent (WTE) palliative care clinical nurse specialists working at the trust, one of whom worked mainly at the Princess Royal hospital. Two nurses were 50% funded by the local hospice. The palliative care staff based at the Royal Shrewsbury Hospital felt staffing levels to be sufficient.
- The trust employed and funded a full time EoLC facilitator from September 2016. The EoLC facilitator worked four days a week at the Royal Shrewsbury Hospital and one day a week at the Princess Royal Hospital.
- Two nurses fulfilled a full time EoLC specialist educational role (job share). This was a secondment opportunity and was due to end in June 2017.The seconded posts were funded by Health Education England.

Medical staffing

- The trust had a consultant physician who was also the EoLC clinical lead on a voluntary basis.
- There were no palliative care consultants employed by the trust at the time of our inspection. The local hospice had 3.7 WTE palliative consultants and provided the hospital with cover; however, this was an 'honorary' post rather than a substantive one.
- Funding for a full time consultant in palliative medicine (with secretarial support) had recently been approved. Shortlisting was in progress at the time of our inspection with interviews due to take place in January 2017. The trust advertised the palliative care consultant post to cover both of the trust's hospitals.

Major incident awareness and training

- We saw that the trust had a major incident plan in place. Senior managers were updating plans to include 'site specific' details for the mortuaries.
- We saw the trust had an operational pandemic influenza policy in draft form that had a mortuary specific section. The policy contained details on the storage of the deceased if the mortuary was to reach full capacity.
- Leaders in the mortuary department were aware of the trust's major incident plans and that they could access them on the internet. They were also able to tell us what would happen in the case of an emergency such as a pandemic.

Are end of life care services effective?

Requires improvement 

We rated effective as requires improvement because:

- We reviewed eight 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.

End of life care

- The trust scored below the national average on all five clinical quality indicators in 2015 and met only one in eight of the organisational benchmarks set in the national End of Life Care Audit. However, we saw that active progress had been made since then to address the key issues.
- The palliative care team only operated during weekdays; within office hours, this meant that people did not receive the same level of service outside office hours.
- End of life care performance measurements were not part of the trusts dashboards.

However:

- Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice.
- The trust took part in the national end of life care audit. The trust had taken a number of actions in response to the audit.
- The palliative care team attended and facilitated a number of training events.
- All of the palliative care team and all mortuary staff had completed an appraisal within the past year.
- Staff from the palliative care team attended regular multidisciplinary team meetings in specialist areas such as brain, lung and cancer of an unknown primary (CUP).

Evidence-based care and treatment

- Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. For example, End of Life Care Plans and documentation for end of life care was in line with best practice from the Leadership Alliance five priorities of care 2014, 'One Chance to Get it Right' guidelines.
- The hospital ensured patients needing palliative care support were identified in a timely way and that the bodies of the deceased were cared for in a culturally sensitive and dignified manner. This was in line with the 'National Institute of Health and Care Excellence' (NICE) QS13: end of life care for adults (2011).
- A personalised end of life care plan was introduced after our last inspection in 2014, following the withdrawal of the Liverpool Care Pathway. The Plan had been developed across all health services within Shropshire. It supported patients in the last few days and hours of life only.
- We did not see any completed End of Life Care Plans on the day of our inspection. This may have been because none of the patients we saw had been identified as being in the last few hours and days of life. One nurse told us that doctors were reluctant to start the plans; another nurse said that the end of life plan was helpful but not often used.
- The trust took part in the End of Life Care Audit: Dying in Hospital (2016) which followed on from The Royal College of Physicians (RCP) published National care of the dying audit for hospitals in 2014. Following the audits, the trust had taken a number of actions. Actions included the implementation of a care after death policy and End of Life Care Plan, a new Swan bereavement suite, end of life care (EoLC) champions assigned to each ward and an end of life resource file for all wards.

Pain relief

- Medical staff prescribed appropriate pain relieving medications.
- The End of Life Care Plan provided a flow chart to guide staff on pain relief. Staff knew where to access the flow chart.
- Ward staff contacted the palliative care team for advice on pain control.
- We spoke to three patients receiving EoLC, all told us that nursing staff had spoken to them about pain relief and that their pain was well controlled.
- The palliative care team responded quickly to support staff in pain management.
- We saw that a pain management plan was in place for a patient requiring an opioid medication.
- We saw that the trust measured their delivery of pain management against the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015) and saw they achieved most of the standards. Of those standards, not met actions had been identified. For example, the trust recognised that clinical nurse specialists in pain management should be able to prescribe independently and were in the process of organising a prescribers course. All nurses on the palliative care team were already nurse prescribers.

Nutrition and hydration

End of life care

- The trust addressed the reduced need for food and drink in an information sheet for relatives. This information sheet was included in the End of Life Care Plan.
- Ward staff told us they could refer to dietitians or speech and language therapists if they had concerns around a patients' swallowing or nutrition. Nursing staff completed and reassessed patient's nutritional risks.
- We spoke with three patients who were happy with the hospital food.
- One patient told us staff had supported them with eating their meals. We observed a health care assistant supporting a patient to eat.
- We saw that patients had access to drinks at all times. One patient told us staff replenished their drinks quickly.
- We witnessed a staff member offer a patient a nutritional supplement; they also offered a choice of flavour.

Patient outcomes

- 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. The trust scored particularly poorly for documented evidence that patients' concerns were listened to (65% against an England average of 84%) and that the needs important to them were asked about (30% compared to an England average of 56%).
- At the time of our inspection (December 2016), we saw there was an action plan in place to address the findings of the audit and that the trust were working hard to improve EoLC. For example, we saw the trust had implemented a bereavement survey and that the End of Life Facilitator was rolling out training on the End of Life Care Plan.
- End of life performance measurements were not part of the trusts dashboards. Senior leaders told us that the end of life care facilitator attended quality and safety committee meetings to share details of the national audit and to share the progress made by the EoLC and palliative teams.

Competent staff

- We found that the End of life Facilitator had trained 1729 clinical staff in EoLC planning up to December 2016. Approximately 2,000 clinical staff still required training.
- We saw that the end of life care team and the palliative care team attended and facilitated a number of training events. Courses attended included current issues in palliative care, dying matters, and an EoLC audit workshop.
- One staff member we spoke to told us that they had been on an end of life study day that covered having difficult conversations, the staff member told us that this had built up their confidence.
- The trust held an EoLC conference in November 2015, which over 160 clinical staff attended. The EoLC lead clinician chaired the conference; subjects discussed at the conference included what is a good death, and the role of the speech and language therapist in EoLC.
- Mortuary staff were trained on how to use hoists and equipment. Leaders trained porters and funeral directors and kept a record of this.
- The clinical lead for EoLC held a teaching session in May 2016 for medical, mortuary and bereavement staff. Topics involved registering a death, bereavement survey feedback and involvement of the coroner in the certification of death.
- Data showed that the trust had trained 41 out of 50 porters in the use of the new X-cube, a three-dimensional frame with a cover, used to transport the deceased from the wards to the bereavement suite.
- All of the palliative care team and all mortuary staff had completed an appraisal within the past year.
- Staff in the mortuary department did not receive bereavement training and felt they needed this to perform their role effectively.

Multidisciplinary working

- Staff from the palliative care team attended regular multidisciplinary team meetings in specialist areas such as brain, lung and cancer of an unknown primary (CUP).
- The trust had identified a lack of palliative medicine consultant input into the CUP multidisciplinary meetings as an operational challenge.
- The End of Life Care Facilitator had been working with the renal unit to prepare a document 'my kidney care': making my wishes known. The document contained example questions that patients may wish to ask staff,

information on power of attorney for health care decisions, living wills and space for the patient to record their wishes, preferred place of care and comments from family members.

- The local hospice funded a palliative care consultant to provide clinical support at the Shrewsbury hospital. We reviewed the hospital specialist palliative care team annual report 2016 and found CUP attendance by a palliative care consultant was 27%, which was significantly below the trust's target of 66% MDT attendance. The trust were interviewing for a consultant in palliative medicine who could attend future CUP meetings.
- We saw that the chaplain attended an eight weekly EoLC project meetings with the EoLC facilitator and nurses from the palliative care team. The team held the meeting to review progress in EoLC and to address any challenges faced.
- Palliative care staff discussed patient outcomes in weekly multidisciplinary meetings. The community palliative care team and the palliative team attended each other's meetings on alternative weeks.
- The trust held a multi-professional dying matters conference in 2016.
- Staff from all areas of the hospital that were involved in EoLC care spoke of a good working relationship with the palliative care team and knew the name of the EoLC facilitator.
- We saw that a multidisciplinary team had been involved in a patient's care and treatment.
- Staff on the hospital wards told us that there were good links and support available from the local hospice.
- Multidisciplinary teams discussed 'defined ceiling of treatment and allow natural death' forms.
- The EoLC facilitator had been working alongside the intensive therapy departments in the development of new ideas.

Seven-day services

- The palliative care service was available Monday to Friday from 9am until 5pm. The local hospice provided out-of-hours support via the telephone.
- Mortuary services were available from 8am until 4.30pm five days a week. Arrangements were in place for undertakers and porters to access the mortuary outside of these hours.
- The hospital chapel was open 24 hours a day, seven days a week for patients, staff and visitors. An on call number was available for chaplaincy services outside of working hours.
- A bereavement officer was available during normal office hours, Monday to Thursday 9am-5pm, Friday 9am-4.30pm.

Access to information

- All staff on the palliative care team had access to software that collected data throughout a patient's cancer journey.
- The palliative care team had access to patients' records on the wards.
- All staff could access the trust's policies and procedures on the intranet. Palliative care staff also had access to information from the local hospice.
- Senior staff kept EoLC information in a resource black box file on the wards. The box contained important EoLC documentation, such as fast-track checklists, syringe driver loan forms and the care after death policy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight defined ceiling of treatment forms where doctors had recorded patients as lacking capacity and found doctors had not completed the required mental capacity documentation.
- Additionally we found that in two instances when 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.
- We spoke with two consultants in relation to completing and documenting mental capacity assessments. Both consultants told us that they were aware of mental capacity documentation but they would not complete this due to the lengthy process.
- Mortuary staff obtained consent prior to carrying out post mortems or tissue donation. Mortuary leaders kept records of consent in a file within the department.

End of life care

Are end of life care services caring?

Good

We rated caring as good because:

- We observed staff treating patients at the end of their lives and the deceased with dignity and respect.
- Patients we spoke with were positive about the care they received.
- Chaplaincy support for patients, relatives and staff was available 24 hours a day. A group of volunteers supported the chaplaincy service.
- The palliative care team could refer patients to the local hospice for bereavement and psychological support.

However:

- Patients did not always know who their palliative care nurse was.

Compassionate care

- The trust had implemented a bereavement questionnaire to relatives following the care of the dying audit 2014. The April to September 2016 survey consisted of 21 questions. The trust issued 848 questionnaires and 183 people responded.
- We reviewed the results from April 2016 to September 2016, which were mainly positive. For example, 89% of respondents felt that if they spoke to a doctor they were given adequate opportunity to ask questions and 89% felt that the hospital was the right place for their relative to spend their last days.
- We observed mortuary and porter staff moving and handling deceased patients with dignity, care and respect.
- We reviewed the care after death policy and found it contained detailed guidance for staff on the spiritual and religious needs of the dying patient. Staff from the mortuary department were aware of different faiths and what this may mean to them. We saw there was a cultural booklet available to all staff at the trust.
- Patients receiving end of life care told us staff were polite, respected their dignity, introduced themselves and maintained their privacy when they provided care and support.

Understanding and involvement of patients and those close to them

- Two out of the three patients we spoke with did not know who their palliative nurse was.
- One patient told us they had been given conflicting information around their diagnosis and that they had been told they would be 'temporarily' moved to a hospice.
- We reviewed bereavement feedback comments from families and friends and saw remarks such as, "We were only ever treated with kindness and compassion" and, "Our questions and queries were always dealt with."
- Staff kept resource files on the wards containing end of life care documentation. We reviewed the contents of a file and found it contained a preferred priorities of care (PPC) document. The document was to give patients the opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. We did not see any of these completed during our inspection.

Emotional support

- Chaplaincy support was available 24 hours a day, seven days a week through an on-call system and across both hospital sites. At the time of our inspection, the service was overstretched and the chaplain was completing a business case for additional support. Chaplains provided emotional support to patients' relatives and staff with the support of a group of volunteers.
- Staff told us that families can visit patients any time when at the end of their life.
- Palliative care staff told us that they could make referrals to the local hospice for psychological or bereavement support.
- The renal department had a clinical psychologist to support the emotional needs of patients and to support patient choice.

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

End of life care

- Sixty-seven percent of respondents in the most recent bereavement survey (April 2016 to September 2016) said there was no discussion about where they wanted their relative to be cared for in their last days.
- There was no specific data on how many people had died in their preferred location or how quick discharge took place in end of life care patients.
- The designated Swan Rooms were not ring-fenced for end of life care patients and so not always available; we were told the rooms were being used for patients requiring isolation.
- The trusts bereavement surveys showed delays in obtaining the medical certificate of cause of death as a concern.

However:

- The palliative care team responded quickly to requests for support.
- The palliative care team were supporting increasing numbers of patients and referrals had increased by 22% from the previous year.
- There was an accessible bereavement suite with suitable viewing areas for children and adults in the mortuary.
- There was adequate fridge storage capacity in the hospital's mortuary department.
- Swan boxes containing tissues, toiletries, jewellery and property bags were available to the recently bereaved.
- A complimentary therapist that worked alongside the palliative care team provided hand and foot massages in addition to aroma sticks to help with nausea and vomiting.
- The hospital chapel catered for patients of a variety of faiths.

Service planning and delivery to meet the needs of local people

- The hospital did not have a designated palliative care ward. Patients received EoLC in a variety of wards within the hospital.
- Ward staff alerted the palliative care team when a patient was identified that would benefit from their service and support.
- The hospital had opened three Swan Rooms for end of life care patients. These were on ward 25, 28 and on the clinical decision unit. The reason for the Swan Rooms was for end of life care patients to be cared for in a more suitable environment. The hospital had newly decorated and furnished the rooms. Ward staff told us they had received positive feedback from family members. Swan Rooms had recliner chairs in them for relatives to use.
- Swan Rooms were not always available for end of life care patients. We spoke to one senior staff member who told us that end of life care patients only used Swan Rooms on their ward once or twice in the last two months. This was due to needing the rooms for patients requiring isolation.
- The chapel was Christian dominated with stained glass windows and an altar area. There was an area for multi-faith prayer next to the alter. The chapel had a sink area and prayer mats were stored in an accessible cupboard.

Meeting people's individual needs

- We visited the Swan Bereavement Suite and saw there were improved visiting areas for adults and children named Swan and Cygnet rooms. Additionally there was designated free car parking for visitors to the bereavement suite and a quiet area outside with a water feature, a gazebo and a variety of shrubs.
- The bereavement suite was wheelchair accessible and had disabled toilet facilities.
- The trust had a dementia service that consisted of a clinical nurse specialist and support workers. Volunteers at the trust were trained to be "Dementia Buddies".
- A learning disability nurse was employed by the trust to support people with a learning disability.
- We reviewed the leaflet titled practical help and support for relatives and friends following the death of a loved one, and found it contained a list of useful contacts for additional support.
- The trusts EoLC draft strategy recognised the need to involve the hospital palliative care team in the care of patients with complex symptoms or other issues.
- The hospital had increased the mortuary's fridge capacity from 48 spaces to 90 spaces and had a fridge large enough to accommodate a coffin or a bed.
- The trust had rolled out the Swan scheme across the hospital, providing resources for staff and practical measures for patients and families that included Swan boxes, bags and end of life information files for staff. A Swan bag was available for bereaved families in the accident and emergency department. This was because the trust felt a box would not always be appropriate if a patient's death was sudden.

End of life care

- The End of Life Care Plan contained a section for medical staff to record the patients preferred place of care.
- Results from the bereavement survey (April to September 2016) identified areas for improvement. For example, 67% of respondents said there was no discussion about where they wanted their relative to be cared for in their last days. Seventy-six percent of respondents said staff did not provide an information sheet following a discussion with staff about end of life care.
- Ninety-seven percent of people who responded to the bereavement survey said they were given a bereavement booklet titled 'practical help and support for relatives and friends following the death of a loved one'.
- One member of the end of life team provided us with an example of when they had supported a patient to go home to die which was their wish.
- We visited the hospital's chapel as part of our inspection and found it to be multi–faith. We saw a variety of prayer sheets for different religions, a copy of the Bible and the Quran. The chaplain we spoke with was knowledgeable of different religions.
- The hospital offered a remembrance photography service for families when they could be photographed holding the hand of the deceased.
- A complimentary therapist that worked alongside the palliative care team provided hand and foot massages in addition to aroma sticks to help with nausea and vomiting.
- Translation services were available 24 hours a day, seven days a week through a telephone service.
- We noted that the trust identified delays in obtaining the medical certificate of cause of death as a theme within the bereavement survey. The EoLC facilitator had devised a flow chart and action plan as a result. An outstanding action was for mapping the process of obtaining the certificate to identify where the delays occurred.
- Mortuary staff told us that there was no facility for families to wash bodies due to health and safety reasons. Mortuary staff could arrange this with the funeral directors if family wished to do this. There was no standard operating procedure (SOP) in relation to this.

Access and flow

- The main reason for referrals to the palliative care team in 2015-2016 was for assessment; other reasons included palliative care and supportive care.
- The main reason for discharge of patients from the palliative care service was due to the referral being for clinical advice.
- The palliative care team took referrals from relatives, the local hospice and other primary and secondary health professionals. Ward staff could refer to the palliative care team by telephone; this meant that ward staff could contact the palliative team quickly.
- We reviewed the trusts specialist palliative care team annual report dated July 2016, and saw that the palliative care team saw the majority of patients (73%) on the same day as referral. A further 296 patients (24%) were seen within two days. Those seen within five days were usually due to a request from the referrer to delay first contact rather than a capacity issue.
- Data showed that the palliative care team had supported 247 patients with a non-cancer diagnosis between April 2015 and March 2016.This was an increase of 58 patients (22%) from the previous year. Non-cancer patients accounted for 22% of the palliative care team's caseload.
- There was no specific data available from the trust on how many patients were able to die in their preferred location. The bereavement survey asked family/friends if they felt the hospital was the right place to spend their last days following the patient's death.
- We saw that there was a fast track checklist available to staff. The checklist provided guidance to staff on what to consider when discharging an end of life care patient. Staff kept fast track checklists in end of life resource files on the wards.
- There was no specific data available on how quick discharge occurred in end of life care patients.
- The discharge liaison team supported patients requiring rapid discharge and occupational therapists became involved if there was a need for equipment. The palliative care team referred end of life care patients to the community team following discharge.
- The palliative care team arranged for the hospice at home service when a care package was not available. The hospice at home service supported patients in their last six weeks of life.

Learning from complaints and concerns

End of life care

- The mortuary department did not receive any complaints between December 2015 and November 2016.
- Data from the trust showed there had been nine complaints in relation to EoLC from December 2015 to November 2016. We reviewed a response letter from the chief executive and saw it contained an apology. The complainant was advised what actions had been taken by the hospital. For example, one action was that the feedback was shared with the end of life team.
- Staff from the palliative team told us that they were not aware of any complaints about palliative care and that complaints were not on their meeting agendas.
- Staff from the palliative care team were aware of the complaints policy and that they could access it on the hospitals intranet site.

Are end of life care services well-led?

Good

We rated well-led as good because:

- The trust had made end of life care (EoLC) one of its priorities in 2015/2016.
- Staff at all levels and from all departments understood the importance of a dignified death.
- Results from audits completed by the palliative care team were presented at the clinical audit committee.
- The EoLC consultant was a member of the trust mortality group and gave feedback on the bereavement survey at its meetings
- There was evidence that learning around EoLC was being shared with staff within the trust.
- The trust had an end of life steering group who met every six weeks; members of the executive team attended these
- Staff were highly motivated and passionate in providing EoLC and that there was a drive for change and improvement of EoLC services at the hospital. Staff we spoke to were positive about the EoLC service and felt it had improved.
- Staff felt supported by their immediate leaders.
- The hospital had recruited EoLC champions on wards who linked in with the end of life care facilitator.
- Staff were proud of the work they did and the trust recognised their achievements.

However:

- There was no EoLC risk register and not all EoLC risks were recorded on the trusts risk register.

Leadership of service

- The end of life care management team consisted of the director of nursing and quality/ executive lead, an end of life care clinical lead, an end of life care facilitator and a non-executive director (NED).
- The head bio-medical scientist oversaw the mortuary department.
- The trust had an end of life care steering group that met every six weeks and members of the executive team attended these meetings. Subjects discussed by the group included those highlighted in the 'Royal College of Physician's', 'End of Life Care Audit-Dying in Hospital' March 2016, for example, the bereavement survey and staff training. The group also addressed issues raised to us during our inspection, such as ensuring there were enough syringe pumps.
- The trust had appointed a lay member on the trust board with responsibility for EoLC. This was a recommendation from Norman Lamb after publication of the review of the Liverpool care pathway in his letter to NHS trust chairs and chief executives in July 2013.
- The director of nursing sat on every committee within the trust and also sat on the trust board.

Vision and strategy for this service

- We saw that the trust had taken the issues raised in our inspection report from 2014 very seriously and taken many actions as a result. This included developing a vision and strategy for end of life care at the trust.
- Senior leaders told us they were working with other providers towards a consistent strategy across Shropshire. The EoLC team's aims for the next five years included ensuring that staff offered patients approaching the end of life in hospital a choice of where they would prefer to die and to get better at considering advanced planning with patients who have life limiting conditions.
- We reviewed the trusts annual review document 2015-2016 and saw that the trust had made EoLC one of its priorities for that year.
- We found that staff at all levels and from all departments understood the importance of ensuring staff provided patients with a dignified death.

End of life care

Governance, risk management and quality measurement

- We noted the mortuary was licenced by the Human Tissue Authority (HTA), the most recent HTA inspection report was dated 2014 and all standards were fully met.
- We saw that a member of the palliative care team presented findings from the EoLC audit 2015 to the members of the clinical audit committee in November 2016.
- Senior leaders told us there was no end of life risk registers and that that any risks would be included within the trust risk register.
- We reviewed the trust risk register dated February 2017 and saw that identified risks in the end of life service were not recorded, for example there was no reference to the lack of a palliative care consultant or that there had been limited consultant cover at MDT's. There were no risks recorded in relation to the hospital mortuary despite concerns around infection control.
- The EoLC consultant was a member of the trust mortality group and discussed the bereavement survey at a meeting attended in November 2015.
- We saw that some medical staff were not completing mental capacity documentation and this was not being challenged.

Culture within the service

- We saw that staff were highly motivated and passionate in providing EoLC and that there was a drive for change and improvement of EoLC services at the hospital. Staff we spoke to were positive about the EoLC service and felt it had improved.
- Staff across departments spoke of good working relationships with the EoLC facilitator and the palliative care team.
- Staff providing EoLC or following a death, felt they worked well together and that their immediate managers provided a good level of support.
- Staff in the mortuary department told us that all members of the hospital's board had been to visit the new mortuary department.

Public and staff engagement

- The hospital had recruited end of life care champions on the wards. The champions linked in with the EoLC facilitator around end of life care.
- The trust recognised staff achievements, for example, we reviewed the trust board meeting minutes dated June 2016 and saw that the EoLC facilitator had received an award of recognition.
- We reviewed the EoLC facilitator's 26-month highlight report 2016, which noted a plan to implement a staff questionnaire to gain information about EoLC support and training offered to staff, and any gaps in the service.
- The end of life care clinical lead gave presentations to senior medical staff at the doctor's essential education programme in 2016. We reviewed the presentation and found it contained information on what is a good death. The clinical lead provided senior staff with information about the bereavement survey, key messages and future developments.
- We saw there was a bereavement survey in place to obtain the views of the bereaved.

Innovation, improvement and sustainability

- The EoLC service depended on third party funding and charitable donations.
- The palliative care team had implemented pocket size cards to assist anticipatory prescribing in the dying patient for health professionals. The cards also contained additional information such as accessing out-of-hours medical advice from the local hospice.
- 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 care patient.
- A complimentary therapist was working with EoLC patients providing hand and foot massages and aroma sticks. The palliative care team told us that they had received positive feedback from patients and loved ones.
- The lead clinician chaired an EoLC conference in November 2015. Trust staff, local clinical commissioning group's (CCG's), care homes, care agencies, hospices and other hospitals attended this conference.
- The palliative care team had developed an information leaflet for patients with contact details and identification of a clinical nurse specialist within the team.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had rolled out the Swan scheme across the trust that 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 care patient.
- 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.

Areas for improvement

Action the hospital 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 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 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

Action the hospital SHOULD take to improve

- 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.

Outstanding practice and areas for improvement

- 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 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 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.
- 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.
- The trust should ensure all staff received an annual appraisal.
- The trust should ensure patient information leaflets can be provided in languages other than English.

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	Regulation
Treatment of disease, disorder or injury	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	Regulation
Treatment of disease, disorder or injury	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.

This section is primarily information for the provider

Requirement notices

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	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
Treatment of disease, disorder or injury	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.