Shrewsbury and Telford Hospital NHS Trust

Inspection report

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

Date of inspection visit: 10, 11 October 2023 and 12,13 November 2023
Date of publication: 15/05/2024

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and 65,000 in mid Wales.

The trust's main service locations are the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury, which together provide 99% of the trust's activity.

Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care.

During 2012/13 the Princess Royal Hospital became the trust's specialist centre for inpatient head and neck surgery with the establishment of a new Head and Neck ward and enhanced outpatient facilities. It also became the centre for inpatient Women and Children's services following the opening of the Shropshire Women and Children's Centre in September 2014.

During 2012/13, the Royal Shrewsbury Hospital became the specialist centre for acute surgery with a new Surgical Assessment Unit, Surgical Short Stay Unit and Ambulatory Care facilities.

Together the hospitals have just over 700 beds.

Alongside services at the Princess Royal Hospital and Royal Shrewsbury Hospital, the trust also provides community and outreach services, such as:

Consultant-led outreach clinics

Midwife-led units

Renal dialysis outreach services

Our findings

Community services including Midwifery, Audiology and Therapies.

Between 10 and 11 October 2023, we inspected services provided by the trust across 2 locations. We carried out an unannounced inspection of End of Life Care, Medical Care (including older people's services) and Urgent and emergency services at the Royal Shrewsbury Hospital. We carried out an unannounced inspection of Children and young people, End of Life Care, Maternity, Medical Care (including older people's services) and Urgent and emergency services at the Princess Royal Hospital.

We inspected these services because during previous inspections we had identified concerns and wanted to check whether the trust had made improvements to the patient care and treatment delivered. We did not inspect any other services at this trust at this time. We continue to monitor other services and will re-inspect them as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed 'is this organisation well-led'.

We inspected the well-led key question between 14 and 15 November 2023. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSE). There was not a separate 'Use of Resources' assessment in advance of this inspection.

Outstanding practice

We found the following outstanding practice within Children and Young Persons:

- The service used sepsis escalation stickers which are situated within the patients records and this identifies patients that require escalation due to their deteriorating health.
- The service implemented and used an eating disorder care bundle which was person centred to each individual young person.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 22 legal requirements. This action related to 6 core services.

Trust wide

- The trust must ensure there is a timely review of all open risks dated from 2009 to 2019. (**Regulation 17: Good governance).**

Our findings

<u>**Royal Shrewsbury Hospital**</u>

Medical Care (including older people's services)

- The service must ensure all staff complete mandatory and legally required training and medical staff complete safeguarding children's level 3 training in line with trust targets**. (Regulation 18 (1) (2) (a)).**

Urgent and emergency services

- The trust must ensure there is clear oversight of all patients in waiting areas. **(Regulation 12(2)(a)(b)).**
- The service must ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. **(Regulation 12(1)(2)(a)(b)).**
- The service must ensure that service users are treated with dignity and respect. **(Regulation 10 (1)(2)(a)).**
- The service must provide care that meets the needs, and reflect the preferences, of patients. **(Regulation 9(1)(a)(b)(c)).**
- The service must ensure patients can access care and treatment in a timely way. **(Regulation 12(1)(2)(a)(b)).**

<u>**The Princess Royal Hospital**</u>

Medical Care (including older people's services)

- The trust must ensure that all risk assessments, with particular attention to venous thromboembolism risk assessments are completed in line with trust policy, to reduce the risk of harm to patients. (**Regulation 12 (1) (2) (a)).**
- The trust must ensure they adhere to the policies in place around mixed sex breaches. (**Regulation 10).**
- The trust must ensure they continue to work on meeting their referral to treatment targets for all pathways. (**Regulation 17 (1) (2) (a)).**
- The trust must ensure all staff complete mandatory and legally required training and receive an appraisal. (**Regulation 18 (1) (2) (a)).**

Urgent and emergency services

- The trust must ensure medicines are stored safely and there is oversight and governance processes in place for the safe storage of medicines including but not limited to patients own medicines and effective monitoring of refrigerator temperatures in order to store medicines safely. **(Regulation 12(1)(2)(e)(g).**
- The trust must ensure that staff comply with nationally recognised infection control standards. **(Regulation 12 (1)(2)(h).**
- The trust must ensure that all patients are triaged in a timely way**. (Regulation 12 (1)(2)(a).**
- The trust must ensure patients can access care and treatment in a timely way. This includes ambulance handover times and patient waiting times for treatment and arrangements to admit, treat and discharge patients. **(Regulation 12(1)(2)(a)(b)**.
- The trust must ensure the mental health room exit complies with statutory requirement. **(Regulation 12 (1)(2)(a).**

Our findings

- The trust must ensure bedrails assessments are carried out on patients who require them in line with national standards. **(Regulation 12 (1)(2)(a)(b).**
- The trust must ensure systems and processes to safeguard patients from abuse and improper treatment are fully implemented. This includes safeguarding checks and assessments are completed and actions taken to safeguard patients are documented. **(Regulation 13 (1)(2)(3).**
- The trust must ensure that patients within all areas of the emergency department consistently have their right to privacy respected. **(Regulation 15 (1)(c).**
- The trust must ensure that environment in all areas within the emergency department are suitable for the purpose for which they are being used. **(Regulation 15 (1)(c).**
- The service must operate effective governance systems to ensure compliance with all relevant sections, such as but not limited to the risk register. **(Regulation 17(1).**

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure compliance for declarations of interest by decision making staff is in line with the NHS Counter Fraud Authority recommended compliance standard of 80%. (**Regulation 19: Fit and proper persons employed).**
- The trust should ensure systems to identify where action should be taken, through internal audit, are robust. (**Regulation 17: Good governance).**
- The trust should consider increasing the exposure of direct reports to trust board in order that succession planning and empowerment continues to develop within the senior team.
- The trust should consider strengthening the Board by the appointment of additional specialists in financial management.
- The trust should consider reviewing the governance structure throughout the organisation in order to ensure that only relevant information is presented to trust board.

Royal Shrewsbury Hospital

End of Life Care

- The trust should ensure that they audit patient discharges undertaken under the fast track system. **(Regulation 12).**
- The trust should ensure the mortuary viewing glass is fit for purpose. **(Regulation 15)**
- The trust should ensure staff are knowledgeable and understand the Mental Capacity Act 2005 and the procedures and documentation used to assess a patient's capacity. **(Regulation 12).**
- The trust should ensure that ReSPECT forms are completed appropriately and consistently. **(Regulation 12).**

Medical Care (including older people's services)

- The service should ensure records are completed consistently to assess and mitigate individual patient safety risks. **(Regulation 12 (1)(2)(a)(b)).**

Our findings

- The service should ensure that deteriorating patients are consistently identified and escalated in line with trust policy. **(Regulation 12 (2)(a)).**
- The trust should ensure checks on resus trolley are recorded as per policy. **(Regulation 12 (2) (e)**
- The trust should ensure nursing and health care assistant staffing levels are as planned. **(Regulation 18 (1)**
- The trust should ensure there is consistent leadership and staffing on the escalation wards. **(Regulation 17 Good Governance (2)(b)).**
- The trust should ensure wards are appropriately equipped to meet patient's needs. **(Regulation 12 Safe Care & Treatment (2)(f))**.
- The service should ensure the storage of medicines within wards are stored safely and securely. **(Regulation 12(1)(2)(g)).**
- The trust should ensure advanced life support and immediate life support training is captured on the trust learning management system. **(Regulation 17 Good governance (1)(2)(b)).**
- The trust should ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line national standards. **(Regulation 17 Good Governance (1) (2) (a).**
- The trust should ensure the store cupboard for clean equipment is moved from the dirty utility room in the discharge lounge. **(Regulation 15 Premises and equipment (1) (f)).**

Urgent and emergency services

- The trust should ensure staff continue to receive hand hygiene training. **(Regulation 12).**
- The trust should consider how it communicates the emergency department is a bare below the elbow environment to internal visitors to the department. **(Regulation 12).**
- The trust should consider how to ensure the premises are secure to protect patients from the risk of harm.
- The service should ensure fire doors are in good working order at all times. **(Regulation 15).**
- The service should consider how it segregates children and adults in the main waiting area. **(Regulation 15).**
- The service should ensure patients have reasonable access to toilet facilities and showers. **(Regulation 9).**
- The service should ensure all patients are issued with an identity band at the earliest opportunity**. (Regulation 12).**
- The service should ensure they introduce a robust way of measuring temperatures for the effective storage of medicines. **(Regulation 12).**
- The service should continue to ensure records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. (**Regulation 17).**
- The service should consider how it introduces a system to ensure the correct use of fluid balance charts. **(Regulation 12).**
- The service should consider applying for a Deprivation of Liberty Safeguard for patient's whose liberty is deprived for extended periods of time in the emergency department. **(Regulation 12).**
- The service should ensure consideration is given to separating people of different genders in escalation areas. **(Regulation 10).**

Our findings

- The service should consider how it introduces a system to monitor 30-day mortality rates for patients delayed for over 5 hours in emergency department. **(Regulation 17).**
- The trust should consider how it develops a system to ensure all staff receive an annual appraisal. **(Regulation 17).**

<u>The Princess Royal Hospital</u>

Children and young people

- The trust should ensure that they complete audits to monitor effectiveness and care for children on neonates. (**Regulation 17).**
- The trust should ensure that the neonates staff receive appraisals. (**Regulation 18).**
- The trust should ensure that all staff in neonates have completed sepsis training. (**Regulation 18).**
- The trust should ensure that all staff complete Mental Capacity Act and Deprivation of Liberty Safeguards training. (**Regulation 18).**
- The trust should ensure that staff are trained and Qualified in Speciality. (**Regulation 18).**
- The trust should ensure that cleaning rotas are completed. (**Regulation 12).**
- The trust should ensure that sepsis trolley within neonates is checked daily**. (Regulation 12).**
- The trust should ensure that fridges are monitored and if broken fixed or replaced. (**Regulation 12).**
- The trust should ensure that the service use electronic system for patient's records. (**Regulation 17).**
- The service should consider when clinical supervisions take place, for these to be documented and a record is kept. (**Regulation 17).**

End of Life Care

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- The trust should ensure staff are knowledgeable and understand the Mental Capacity Act 2005 and the procedures and documentation used to assess a patient's capacity. **(Regulation 12).**
- The trust should ensure that ReSPECT forms are completed appropriately and consistently. **(Regulation 12).**

Medical Care (including older people's services)

- The trust should ensure the governance system in place is effectively supporting all aspects of safe, quality care. **(Regulation 17).**
- The trust should ensure that patients are screened and treated for sepsis in line with recommended guidance and trust policy. **(Regulation 12).**
- The trust should continue to work on the completion and quality of care records. **(Regulation 17).**
- The trust should ensure to continue to use the audit data to drive improvements for patient care and treatment. **(Regulation 12).**
- The trust should continue to work with partner organisations to improve discharges. **(Regulation 12).**

Our findings

- The service should continue to improve the care provided to patients living with dementia which includes improving the environment. **(Regulation 12).**
- The service should ensure all patients are able to discuss any concerns with staff. **(Regulation 12).**

Urgent and emergency services

- The trust should ensure that emergency department records are stored securely in all areas. **(Regulation 15).**
- The trust should ensure regular medication is prescribed in a timely manner. **(Regulation 12).**
- The trust should ensure all staff caring for patients receive a handover to enable them to provide safe care and treatment. **(Regulation 12).**
- The trust should ensure the privacy and dignity of all patients is maintained at all times. **(Regulation 10).**

Is this organisation well-led?

Our rating of services stayed the same. We rated them as requires improvement because:

- There was the leadership capacity and capability to deliver high quality, sustainable care. Leaders were visible and approachable. However, direct reports were not always used effectively to support the board.
- There was a clear vision and credible strategy to deliver high-quality sustainable care to people. However, competing priorities and financial challenges could delay the delivery and ultimately the success of the strategy.
- There was an improving culture of high-quality, sustainable care. Staff we met felt supported, respected, and valued.
- Responsibilities, roles, and systems of accountability to support good governance and management were clear. However, governance structures were still developing and there was limited assurance around financial governance.
- Processes for managing risks, issues and performance were improving but not yet embedded. It was clear the board were sighted on the significant risks across the organisation. However, this was not always clearly articulated through the risk register, Board Assurance Framework or supporting assurance committees.
- Appropriate and accurate information was being effectively processed, challenged, and acted on. There had been a huge amount of work completed on the digital agenda to bring it from a low baseline to a developing service.
- People who use services, the public and staff were highly engaged and involved to support high-quality sustainable services. However, given the significant operational and financial challenges facing the trust, greater partnership working is needed.
- Staff described being committed to continually learning and improving services. The trust had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We rated children and young people at the Princess Royal Hospital as overall good for all domains. We rated medical care (including older people's care) at the Princess Royal Hospital as requires improvement for safe, effective, responsive and well led and good for caring. Urgent and emergency care at Royal Shrewsbury Hospital, we rated safe, caring and well led as requires improvement with effective rating as good and responsive as Inadequate. Urgent and emergency

Our findings

care at the Princess Royal Hospital, we rated safe and responsive Inadequate, caring and well led as requires improvement and effective as good. Medical care (including older people's care) at Royal Shrewsbury Hospital, we rated safe, effective and caring as good and responsive and well led as requires improvement. We rated End of life care across both sites as good overall. We rated maternity overall rating of good**.**

In rating the trust, we took into account the current ratings of services that were not inspected this time.

We rated the trust as Requires Improvement overall because:

- Staff did not always complete all risk assessments. Staff did not always keep good care records.
- Managers monitored the effectiveness of the service however, there were some outcomes which required improvement.
- Not all staff received an appraisal.
- The performance of the service was not always sustainable, a number of metrics showed deterioration shortly after improvement.
- The managers stated that clinical supervision took place, however this was not documented.
- Staff in some areas did not always treat patients with compassion and kindness, respect their privacy and dignity, take account of their individual needs, or consistently support patients to make decisions about their care.
- People could not always access the service when they needed it and sometimes had to wait a long time for treatment. The service could not always be delivered to meet the changing needs of the local population.
- Medical and nurses mandatory training including safeguarding children and adults' level 3 training did not meet the trust's target. Advanced life support and immediate life support training was not captured on the trust learning management system.
- The service did not always control infection risk well, not all staff understood how to protect patients from abuse. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. We had significant concerns around oversight of the patients who were waiting to be seen and the lack of flow through the emergency department which contributed to delays.
- People did not always have timely access to the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The governance structure was not fully effective. Leaders and teams did not effectively use systems to manage performance. They did not always identify and escalate relevant risks, issues and actions to reduce their impact.

However:

- The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued.
- Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well.

Our findings

- Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Managers mostly made sure staff were competent.
- The service made it easy for people to give feedback.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

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

Leadership

There was the leadership capacity and capability to deliver high quality, sustainable care. Leaders were visible and approachable. However, direct reports were not always used effectively to support the board.

Leaders had the skills, knowledge and experience that they needed, both when they were appointed and on an ongoing basis. The trust board was made up of the chair and chief executive, 4 executive directors, 6 non-executive directors and 1 associate non-executive director. The chief executive led the executive directors. Each executive had their own clinical/functional responsibilities, as well as being a corporate member of the board.

Without exception, the leadership team demonstrated a long-term commitment and desire to improve the trust with patient experience clearly at the heart of everything they did. It was recognised that for many of the executive team, it was their first director post. There was a board development plan in place and executives had either or both, a coach or mentor in place to support their own development.

The chair of the trust met with non-executive directors bi-weekly to discuss any emerging risks and where they could provide support to the directors. There were a couple of associated non-executive director vacancies. The executive team had completed a skillset gap audit and were targeting the recruitment process to attract candidates who would be able to fill these gaps, to ensure that the board had the right people with a diverse skillset to lead the organisation.

The Chief Pharmacist had been in post for 6 weeks at the time of the interview. To ensure visibility, they visited both hospital pharmacy locations twice a week for staff meetings and to gather the views of staff with the aim to achieve consistency across pharmacy services. There was a senior pharmacy leadership presence across both sites which ensured there was operational oversight.

There were challenges to the quality and sustainability of the pharmacy service which was primarily due to a national hospital pharmacy workforce shortage. The pharmacy service had a 30% vacancy rate and a high rate of sickness. This meant there was a reduced level of service to some areas. To offset the vacancies, there was ongoing discussions with the Integrated Care System (ICS) about partnership and collaborative sharing of staff skills.

Our findings

It was recognised that due to the staffing issues it made progression difficult. However, staff commented that although opportunities to develop were not always available, there was opportunities for student technicians to develop through an apprenticeship programme and pre-registration pharmacists also remained within the trust following registration.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of 3 executive directors and 3 non-executive directors to determine the necessary fit and proper person checks had been undertaken. Our checks included individuals who had been in post for less than 12 months at the time of this inspection. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files were fully compliant with FPPR.

However, during our inspection of well led, concerns were raised around the current compliance rate for declarations of interest by decision making staff. Compliance was 39.5%, against the NHS Counter Fraud Authority recommended compliance standard of 80%. This had been raised at the audit and risk assurance committee in October 2023 and staff told us work was underway to raise awareness amongst the executive team.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them, this was seen to be a significant improvement since our last well led inspection of this trust. Previously, there had been a lack of stability at trust board level including the executive team, which had led to a poor culture and a fragmented approach to quality and sustainability. The longevity of the board with key members in their third year had enabled a stable trust board working collectively and taking responsibility for the success of the organisation as a whole. Leaders were united in their understanding of the challenges the trust faced and focused on what action they needed to take with the Hospital Transformation Plan seen as the long term solution to improving the way hospital care was to be delivered across Shropshire, Telford and Wrekin and mid-Wales. Leaders were visible and approachable. We observed a highly visible, open and transparent board who were clear regarding their priorities for ensuring sustainable, compassionate, inclusive and effective leadership. However, with so many priorities, there was a risk of leadership burn out. Therefore, the importance of involving and empowering direct reports to drive the day to day management of the operational agenda needed further consideration.

Despite this, under the support of individual directors, there were teams who had been recognised for their experience and capabilities and were empowered to lead in their field of expertise. For example, the safeguarding team, which included leads for mental health and dementia, were a strong team who were very patient focused and clearly leaders in their field. This demonstrated to us that safeguarding was robust and well managed across the trust.

There was a leadership development programme in place that brought together all types of learning opportunities available to trust staff at all stages of their career. We reviewed the trust’s talent management and succession planning timeline due to be fully realised in December 2023. Key to this timeline was a recognition that frontline and/or support staff were the future leaders and/or senior managers of the organisation. Training and/or development opportunities enabled everyone in the trust to discover their full leadership potential.

However, succession planning for direct reports, whilst in place, did not appear sufficiently robust. We heard of many examples where exposure at trust board was limited to board directors with little opportunity for deputies and/or performance report authors to attend. Encouraging authors to present their work and attend board is good practice,

raises their profile and empowerment and as confidence grows, would enable the board to focus more on the strategic direction of the trust. However, the trust were part of a regional succession programme and work was being undertaken at the time of the inspection regarding the leadership framework which supported the development of the trust's future diverse talent pipelines.

Vision and Strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care to people. However, competing priorities and financial challenges could delay the delivery and ultimately the success of the strategy.

The trust had a clear vision and a set of values, with quality and sustainability as the top priorities. The trust vision, 'to provide excellent care for the communities we serve' and values; Partnering; Ambitious; Caring; Trusted, was underpinned by an ambitious 5-year strategy. The trust were focusing on 6 strategic themes to deliver their vision, these were continually reassessed to check that the trust were continuing to respond to challenges in the local community, reducing health inequalities and improving population health and well-being. The trust engaged both externally and publicly around the trust vision and strategy. Non-executive member led a public assurance forum with the community and over 3,000 people had signed up to receive updates.

The 2022-27 trust strategy set out the trust's ambitions, detailing the ways in which the trust would improve the delivery and quality of patient care, support and develop the workforce, address key challenges, and further develop a culture of improvement across the organisation. Importantly, it also described the values and behaviours to which the trust were committed. Through their collaborative working with the Shropshire, Telford and Wrekin (STW) ICS, the strategy aligned to the ICS Joint Forward Plan (2023-28).

The vision, values and strategy had been developed in collaboration with staff, people who used services and external partners. The vision, values and strategy were interlinked and complemented 6 supporting strategies.

There was a robust strategy for achieving the priorities and delivering good quality sustainable care. However, there was a significant amount of work to be done to fully realise the strategy with huge importance being placed on the Hospital Transformation Plan. Competing priorities in, for example, urgent and emergency care and workforce could delay progress. During our core service inspections, staff raised concerns around medical workforce rota covering challenges within urgent and emergency care across both sites and cardiology department where the trust should have 12 cardiologists but only had 2 in post. Cardiology backlogs were increasing, and this was causing further delays around capacity and flow. In addition, there were financial challenges across the trust, that the trust was sighted on but not yet able to resolve. The overwhelming consensus from the executive team was that the strategy had to succeed to enable the trust to move forward, key to this would need to be the collaborative working with system partners.

There was a 5-year medicine optimisation operational policy. Not all staff had felt involved or been asked to contribute to its development. This was recognised by the chief pharmacist who agreed it needed reviewing and would need the inclusion and contribution from all pharmacy staff.

Most staff, we spoke with, during our core service inspections, knew and understood what the vision, values and strategy were and their role in achieving them. The vision, values and strategy had been developed in collaboration with staff and staff were able to keep up to date with progress through the trust intranet, regular bulletins and through visual displays across the trust.

Our findings

Progress against delivery of the strategy and local plans were monitored and reviewed with an update provided to board quarterly. Board papers we reviewed for October 2023, showed the strategy had been reviewed and progress against key milestones assessed. In addition, continued alignment with the Integrated Care Board (ICB) strategic direction, as well as strategies of local partners, had been considered. The supporting strategies were monitored to reflect progress. For example, the trust were in the process of reviewing the Equality, Diversity and Inclusion Strategy, led by the director of people and organisational development; and the trust were commencing a review of the End-of-Life strategy, led by a lead consultant. The Research and Innovation strategy was being finalised and was expected to be published soon.

Culture

There was an improving culture of high-quality, sustainable care. Staff we met felt supported, respected and valued.

There had been a positive shift in culture since our last inspection. We had received overwhelmingly positive feedback about the board, and the direction of travel the trust was taking.

Each autumn everyone who works in the NHS in England is invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements.

The most recent national survey was undertaken in Autumn 2022 and was completed by 3,392 staff at the trust, a response rate of 49%. The national average response rate across comparable organisations was 44%. Although the trust had remained below average, it had improved in all 9 elements of the People Promise and themes.

Staff we met felt supported, respected and valued. The culture centred on the needs and experience of people who used services. The weekly executive team meeting started with a quality agenda item to reflect why the people they served.

Leaders within the women's and children's division identified a number of enablers to the implementation of the maternity improvement plan. These included the strength and support from the senior executive team and empowerment to set standards and deal with concerns with full executive support.

They described the relationship as "unique". As a result of the trust's success with the Maternity Transformation Assurance Committee (MTAC), the trust had implemented the role out of the Paediatric Transformation Assurance Committee (PTAC). Leaders described "a hunger" for improvement across the trust. Learning from maternity had been shared across 130 trusts nationally. Staff reported a difference in the executive team thinking. An open management style had enabled staff to develop ideas for staffing and recruitment in order to look at new roles and retirement forecast to ensure continuity in growth.

The Ockenden review into the trust's maternity services highlighted the need for a development programme for all maternity and neonatal leadership teams to promote a positive culture and leadership. The trust developed and rolled out a programme, created within the maternity services, as a national programme was not available at that time. Senior leaders within maternity were invited to share what they had done with the national team in order that the work they had done could form part of the NHS England training programme. Maternity staff were also enrolled on the national course to ensure a developed and sustained culture of safety.

Our findings

Leaders and all staff we spoke with understood the importance of supporting an open culture where patients, their families and staff could raise concerns without fear and the importance of appropriate learning and action being taken because of concerns raised.

The trust had appointed and embedded a Freedom to Speak Up (FTSU) Guardian and staff were supported to raise concerns. Processes had been reviewed to enable the Guardian to report to the board on a quarterly basis. In between reporting, the Guardian had monthly meetings with the heads of nursing and the non-executive director lead. They also worked collaboratively with human resources (HR) and employee relations to find solutions to some of the concerns raised. The Guardian felt empowered and invested in by the trust leaders. However, it was felt that ambassadors did not necessarily feedback all low-level information. This meant the board were not always sighted on smaller concerns affecting staff.

Staff felt able to raise concerns without fear of retribution. Staff raised concerns or issues with their managers and would also report through the FTSU process. A recent reduction in FTSU contacts was understood to be because of staff having more confidence to raise concerns directly with managers for action.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Reporting to the FTSU Guardian had decreased since our last inspection with 302 contacts in 2020/21 being reported, 369 contacts in 2021/22 and 282 to date for 2022/23.

Since our last inspection improvements had been made in process, with an improved escalation and feedback process to both staff and the trust, improved data collection and theming of trends to collate action plans. However, triangulation between HR and FTSU continued to be an area for improvement to ensure all emerging themes of concern were captured. Regular meetings were taking place where appropriate to allow HR and the FTSU Guardian to triangulate data in order to ensure matters were appropriately being managed and colleagues supported. There was a difference in culture and consistency between the 2 pharmacy departments. Staff said there had been some challenging and difficult times due to staff shortages, particularly at the Royal Shrewsbury Hospital and the pressure that caused on morale and wellbeing. However, there was a more positive culture recognised at the Princess Royal Hospital with integrated team meetings to discuss issues and share learning.

Staff felt that the new chief pharmacist was approachable and listened to staff concerns. It was recognised by staff that there was some work to do to standardise working across the 2 sites and the initiation of cross site meetings would help.

Staff we met felt proud to work in the organisation. They could articulate how the culture in the trust had improved over the past 3 years and that they felt safer to speak up. Despite this, many staff still described feeling ‘traumatised’, as a result of the past challenges faced by the trust. The trust had implemented a psychology hub, where staff as individuals or within teams, could access help and advice to support their mental health and wellbeing. However, we heard from staff side representatives about pockets of staff groups and/or areas, where concerns around bullying and harassment continued.

There was a 3-year strategy for Our People, the trust was in year 3, which featured wellbeing. We met the staff running the wellbeing service and talked about the strategy and services they provided or offered. As well as the lead for health and wellbeing, there were wellbeing champions.

The trust had introduced a culture dashboard. The culture strategy was implemented in 2022, to support the overall cultural transformation for the trust. The strategy used 4 key areas of focus and was measured by the ‘culture dashboard’. The culture dashboard showed 6 key themes, using data taken from the NHS Staff Survey results each year.

Our findings

In order to remove barriers and help staff reach their full potential, the culture dashboard enabled the trust to understand the current culture. From this, the trust was able to determine what was needed for staff in terms of behaviours, skills and capability and what was getting in the way of consistently high performance in all areas of the trust.

There was a strong emphasis on the wellbeing of staff. The director of People and Organisational Development chaired the culture workstream which was driven by the voices and views of staff.

The trust had signed up to the NHS "Sexual safety in healthcare: Organisational charter" released in September 2023. Trusts were required to have implemented the charter, which required organisations to "commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce." The trust acknowledged that they were in the first stages of thinking about how they would implement a sexual safety charter and were working with a local trust to support this. The plan was that this would be completed by summer 2024.

There were mechanisms for providing all staff at every level with the development they needed, including appraisal and career development conversations. Most staff felt there were opportunities for development and training.

The trust had 3 equality, diversity and inclusion (EDI) staff networks for, race, disability and LGBTQIA+. Each had an executive sponsor. As part of the NHS Improvement Plan published in June 2023, the trust were developing measurable objectives for each board member in relation to equality, diversity and inclusion, and health inequalities.

The trust celebrated religious festivals and cultures. There was an equality and diversity calendar where staff could come together to celebrate and learn about events. The week of our inspection, there had been a roadshow to celebrate Diwali.

The October 2023 trust board report into the Workforce Race Equality Standard (WRES) 2022 provided an executive summary. The action plan demonstrated planned work in 2023/24 to address the areas of concern highlighted. The action plan was monitored through the Equality Diversity and Inclusion Group and assurance of progress reported to the People Committee. WRES and Workforce Disability Equality Standard (WDES) areas of concern and improvements included:

- Trust data showed ethnic minority staff experiencing harassment, bullying or abuse from staff in the last 12 months in the organisation was 21.7% (down from 24%), which was worse than the national average of 17.3% in 2022.
- The need for greater participation in staff survey to improve the strength of data; 49% last year with a target of 49 to 51% in 2023/24.
- The need for equal opportunities for career progression and promotion. Data showed that staff from other ethnic groups reported about 10% more negatively in this area. To address this, the trust had introduced the Galvanise Leadership programme and launched new Talent Conversations to support ongoing development.

A number of Initiatives had been introduced and improvements made in 2023 to address the trust's concerns. One notable initiative was the Galvanise programme. Galvanise was an ethnic minority leadership programme. The programme's goal was to ensure that ethnic minority colleagues had a space to come together and share challenges and opportunities. To date, 20 staff at the trust had taken part in the Galvanise programme.

Our findings

The trust was required by The Equality Act 2010 to publish an annual gender pay gap report. The last was published in March 2023. The gender pay gap is the difference between the median or mean hourly rate of pay to male and female staff. The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women.

Trust data on 31 March 2022 showed:

- The difference of 25.24% between the mean hourly rate of pay for male employees and mean hourly rate of pay for female employees, with men earning £5.61 per hour more on average. This had improved from £5.94 (2020) and £5.76 (2021).
- The difference of 9.24% between the median rate of pay for male employees compared with that of female employees, with men earning on average £1.49 more an hour.
- In respect of 'the gender bonus gap' there was a 35.56% difference in favour of male employees in the level of mean bonus payments made to male employees when compared with female employees. Similarly, there was a 33.33% difference again in favour of male employees when comparing the median bonus level for male employees with that of female employees.

Although there were some improvements in relation to the average gender pay gap for all staff over the last 3 years, a gap between the earnings of men and women remained, with male staff receiving a higher proportion of pay than females. One of the high impact actions within the trusts Equality, Diversity, and Inclusion Improvement Plan was to 'Develop and implement an improvement plan to eliminate pay gaps'. However, when we ask the team leading this, they were unable to clearly articulate how this was being achieved and that it was a working progress.

Participation in WRES, WDES, and gender pay gap reporting were part of the control measure on the board assurance framework to combat a shortage of workforce capacity and capability leads to deterioration of staff experience, morale, and well-being.

Governance

Responsibilities, roles and systems of accountability to support good governance and management were clear. However, governance structures were still developing and there was limited assurance around financial governance.

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were in place but not always effective. For example, although numbers were low, there remained a number of out of date policies meaning staff would not always have the correct guidance to follow when delivering care, there was a lack of awareness of the conflicts of interest policy within key decision making groups, impacting on the Counter Fraud Authority standards compliance. However, since the inspection, the trust had progressed its ongoing work in this area, which included face to face training sessions with decision-making colleagues, and focussed communications leading to significant improvements. Whilst culture was improving, some metrics seen in the WRES, the WDES and the NHS Staff Survey indicated there was still a way to go for the trust.

The board received its assurance through sub-committees, each under the chairmanship of a non-executive director, with appropriate membership or input from members of the executive team. A committee and assurance structure, which included divisional governance arrangements was in place to ensure all levels of governance and management

functioned effectively and interacted with each other appropriately. This allowed for the appropriate communication of key information, including performance and risk, from 'ward to board'. In addition, the senior leadership committee, the monthly communications cascade and divisional and operational meetings all provided forums at which risks to the trust were considered.

Standing items on the board meeting agenda related to strategy, governance, patient feedback, quality of care, people issues, integrated performance and summary reports of the board's sub-committees. The board assurance framework (BAF) was also reported on a quarterly basis as a standing agenda item. The BAF outlined the risks to achievement of the trust's strategic objectives.

The quality governance framework was implemented across the trust in November 2021. Throughout 2022/23 the trust had continued to embed this framework within the divisions to reduce variation and to standardise divisional quality governance processes. In 2022, the previous resources within the patient safety team were realigned with divisional quality governance teams to develop and embed good governance processes.

Staff at all levels clear were clear about their roles and understood what they were accountable for, and to whom.

The trust chair proactively encouraged board members to constructively challenge and explore proposals made to the board and assist in developing proposals on strategy, priorities, risk mitigation and standards. Through our observation of a trust board meeting, we thought there was good initial challenge, particularly around finance. It was clear board members had read the papers and had questions based on the information contained in them, but once their initial questions had been answered, we saw limited continued challenge.

Medicine optimisation was integrated into the clinical support team mainly because the chief pharmacist was accountable to the director of clinical support with access to the medical director. There was a governance structure in place for the safe use of medicines with reporting lines between committees such as the safe medicine practice group (SMPG), drug and therapeutics committee and the integrated medicine optimisation group. The chief pharmacist chaired the SMPG every quarter to present reviews of medicine incidents and highlight any trends. This ensured that medicine optimisation was integrated into the trust governance structure.

Governance arrangements were in place to manage the provision of homecare services which was managed within pharmacy. The Outpatient Parenteral Antibiotic Therapy (OPAT) service was about to start with support from pharmacy.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. An internal audit of duty of candour (July 2023) showed, all elements of duty of candour had been fully met in 113 out of 115 cases (98%).

During 2022/23 the Review, Action and Learning from Incident Group (RALIG) and Nursing Incident Quality Assurance Meeting (NIQAM) had been embedded to enable a multidisciplinary/cross divisional review and shared learning in the trust.

Arrangements with partners and third-party providers were not always effective. Without exception, all members of the board were committed to working in partnership with stakeholders across the integrated care system to improve health outcomes for the communities served by the trust. However, relations with the Integrated Care Board (ICB) were described as being focused on performance management rather than partnership.

Our findings

Despite this, there had been significant success in maternity services through partnership working. The Ockenden Report Assurance Committee (ORAC) was established in March 2021 to review and monitor progress against actions identified in the independent review of maternity services. Representation includes the ICB, Maternity and Neonatal Voices Partnership (MNVP), Healthwatch and NHS England. Progress from ORAC was reported monthly to the board, in addition to, regular reporting of progress through the work of the maternity transformation assurance committee.

Financial Governance

At the time of the inspection, the trust was forecasting that its annual deficit would be around £106 million.

External auditors had given an unqualified opinion on the 2022/23 accounts, including the value for money opinion covering arrangements for securing value for money; governance and financial sustainability. The trust's internal audit provider had given the trust substantial assurance about the operation of its internal controls.

At the time of the inspection, there were significant numbers of recommendations made by internal audit and accepted by management that were overdue for implementation. Despite extensions to deadlines and changes to accountable personnel, 7 high-risk recommendations remained overdue. The trust had added a new risk in April 2023 to its Board Assurance Framework (BAF Risk 2); "The trust is unable to ensure robust corporate governance arrangements are in place; resulting in poor processes, procedures and assurance."

The chair of the audit and risk assurance committee was not an accountant but had significant NHS experience. The chair of the finance and performance committee had significant experience in financial leadership; but was also not an accountant. The trust had recently appointed a non-executive director with relevant accounting and financial management expertise who was a member of the audit and risk Committee.

Management of risk, issues and performance

Processes for managing risks, issues and performance were improving but not yet embedded. It was clear the board were sighted on the significant risks across the organisation. However, this was not always clearly articulated through the risk register, Board Assurance Framework or supporting assurance committees.

There were assurance systems in place in order that performance issues could be escalated appropriately through clear structures and processes. Progress against the priorities detailed in the trust's strategy was monitored through existing assurance committee structures and onward reports to the trust board. Key to this were assurance systems at every level throughout the trust, enabling effective upward reporting from 'ward to board'.

Committees reported to board through the highlighting of Alert, Assure, Advise, at the head of each board meeting. An initiative based on the work of the Good Governance Institute; the report provided a simple way for committees to report to board. Items included as "Alert" to the board were said to be treated as workplan priorities. However, we saw and were told, the many layers of assurance meetings throughout the trust often meant reports to the assurance committees were heavily detailed giving an almost monitoring function as opposed to committees receiving assurance. This was apparent in the minutes we reviewed for the people and organisational development assurance committee.

Our findings

Processes were in place to manage current and future performance. The integrated performance report was presented to public board bi-monthly via the board assurance committees. The report delivered to the board an overview of performance indicators. The report was regularly reviewed and improved, with a brief forward look using data analysed over a period, which helped to indicate themes and areas of potential higher risk, and the actions being taken to mitigate such risks.

There was a systematic programme of clinical and internal audit in place to monitor quality, operational and financial processes. However, systems to identify where action should be taken were not robust. Concerns that would have been worthy of escalating (for example the delay in implementing high-risk internal audit recommendations) were not included in recent reports to the board.

Arrangements for identifying, recording and managing risks, issues and mitigating actions had not been robust. In July 2023, 110 open risks had been identified by the risk management group (RMG), dated from 2009 to 2019. At that time, this equated to approximately 25% of the open risk register. As a result, all risks up to and including end of 2019 were to be closed and refreshed with a new date of 2023. As of October 2023, and following a list of criteria agreed by the RMG, 4 risks had been reviewed and refreshed with a new date of 2023.

Since June 2023, the RMG had undertaken a number of measures to improve risk management processes at the trust including for example, the rollout of risk management training and a review of the risk management policy, strategy, risk assessment form and the risk management group terms of reference. The senior leadership team recognised that, given the cultural change at the trust was still on an improving trajectory, it would take time to embed these new processes.

The risk management policy and process document had been reviewed, as had the risk management strategy and risk assessment tool. These documents were to be taken to the Audit Risk and Assurance committee (ARAC) in December 2023.

A risk management update report was presented to board bi-monthly, and oversight of risks were considered monthly at the audit and risk assurance committee. The trust's risk management position in September 2023 was 445 open risks, extreme risks (≥15) 115, risks overdue for review 191 and overdue actions 391.

The trust had a BAF in place. Work to review and refresh the BAF content for the 2023/24 financial year was undertaken during the end of June and early July 2023. The BAF set out 12 risks that reflected the strategic risks within the trust and aligned with what staff told us was on their 'worry list'. The purpose of the BAF was to outline the risks to achievement of the trust's strategic objectives however, it was not clear from the BAF which risk(s) related to which strategic theme leaving staff in danger of being unable to effectively measure the progress or success of the strategy.

The pharmacy department had its own risk register. The main risk for the medicine optimisation service was the lack of capacity and vacancies within the pharmacy team to cover every specialist area of the trust.

An audit and review of aseptic manufacturing services by the Specialist Pharmacy Service (SPS) on 28 June 2022, found that although products were made safely, there were high risk implications for the safety of the service due to the resources available to maintain and manage the system. An action plan was in place to resource the unit and improve the governance structure to support it. The manufacturing aseptic team were working hard to ensure patients received their treatments, but it was recognised there was pressure on the team.

Our findings

Potential risks had been taken into account when planning services. For example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The trust had a mature suite of plans to deal with major incidents and business continuity issues. These conformed to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans had been developed in consultation with local and regional stakeholders to ensure cohesion with their plans.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. The trust was required to deliver an efficiency and productivity saving as part of its financial plan for 2023/24 in addition to, contributing to a system-wide efficiency target. Maintaining the safety and quality of services alongside the delivery of cost improvement plans (CIPs) was an essential requirement for the trust. The trust had a quality impact assessment (QIA) process in place and despite the significant financial challenges the trust faced, trust leaders were determined in their efforts to ensure these did not compromise the quality and safety of care for their patients.

Information Management

Appropriate and accurate information was being effectively processed, challenged and acted on. There had been a huge amount of work completed on the digital agenda to bring it from a low baseline to a developing service.

There was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances and we saw where information was used to measure for improvement, not just assurance.

Data and information provided on incidents / serious incidents was presented to public board bi-monthly, with prior assurance received through the quality operational committee and quality and safety assurance committee. We reviewed the incident overview reports for June, August and October 2023. Reports were comprehensive and highlighted the patient safety development and forthcoming actions for oversight. An overview of the top 5 reported incidents for the preceding 2 months, was given which included serious incidents. Further detail of the number and themes of newly reported serious incidents and those closed were included along with lessons learned and action taken.

Despite a backlog of incidents (overdue for investigation) of 1,600, which had reduced from 2,400 in March 2023, mitigations were in place to ensure, where appropriate, immediate actions had been taken to protect patients from being further exposed to the risk of harm should a similar incident occur. All incidents were reviewed daily by the quality governance/safety teams who filtered out those incidents that required immediate actions. Moderate harm or above incidents were reviewed at the weekly RALIG. All divisions had a weekly incident review meeting to prioritise and escalate incidents. For example, Neonatal and Obstetric risk meeting, Medicine incident review group and the Emergency Department weekly incident review.

The monthly financial performance report was presented at private board. We reviewed the private board minutes for August 2023 which indicated, there had been significant challenge by members of the board.

Quality and sustainability appeared to receive sufficient coverage in relevant meetings at all levels. Our review of board papers and attendance at both public and private board confirmed staff had sufficient access to information and we observed appropriate challenge by board members.

Our findings

Service performance measures were clear and reported via the integrated performance report. The report provided clarity over the performance indicators which the board monitored including, patient safety, clinical effectiveness and patient experience, responsiveness, workforce and finance. Arrangements were in place to ensure that the information within the integrated performance report was accurate, valid, reliable, timely and relevant. The report provided clarity over the performance indicators which the board monitored. Excerpts of the report, and performance indicators, had been previously reported at a number of operational and leadership groups and committees. Our review of this report demonstrated where action was taken when issues were identified. Each performance indicator included a summary, recovery actions and anticipated impact and timescales for improvement.

Information technology systems were under development. The trust had developed a digital transformation programme since our last inspection. Previous systems had led to the programme requiring an increased level of funding to align with current technology in other trusts.

The strategy for development had been developed over a 12-month period in conjunction with business intelligence and was aligned to the hospital transformation plan. Prior to this there had been no business intelligence unit (BIU). The teams had close working links with the Senior Information Risk Owner (SIRO), cyber team, information governance (IG) committee and data security and protection toolkit standards. A new patient administration system (PAS) was to be introduced April 2024 along with, developments across the trust to aid the implementation of electronic patient records (EPR). There was a good appetite at board level for continued development and this was being delivered trust wide, including upgrades to equipment and medical devices to ensure future proofing. The team had invested in staff development and training in order to implement the significant changes required. The service improvement team at NHS England had supported staff with ongoing project management training to aid implementation.

The business intelligence team were able to provide robust data to the board and had the resilience to continue with this.

For example, referral to treatment information was produced automatically by the BIU, allowing other staff to focus on developing the learning for EPR. The risks across the different information management systems were known. For example, the internal medicine management discharge programme was out of date and needed replacing. A business case was in place for Electronic Prescribing Medicine Administration which was part of the digital strategy for the trust. However, it could not be implemented until the EPR system became operational in December 2023.

There were service performance measures in place with quality monitoring of data. Performance metrics were looked at monthly.

The chief pharmacist was the controlled drugs accountable officer and would ensure that any controlled drug incidents were reported to the Controlled Drug Local Intelligence Network.

The trust were open and transparent in their dialogue with robust arrangements in place to ensure that data and/or notifications were submitted to external bodies, including the CQC as required.

Arrangements (including appropriate internal and external validation) were in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. The trust had a Senior Information Risk Owner (SIRO), a Caldicott Guardian, Information Governance Manager and a Data Protection Officer who were responsible for the management of patient information, patient confidentiality and

information security. The SIRO was committed to ensuring that personal data was protected, and any confidential data was used appropriately, and lessons were learned when there were data security breaches. The SIRO ensured that there was effective information governance in place. The SIRO chaired the data protection and cyber security panel which reported to the audit committee and to the board.

The trust had access control systems in place to allow only those that had a legitimate reason to access personal and health information and systems and processes to verify who had accessed records. All trust staff were required to complete annual mandatory Data Security and Data Protection training and comply with the trust's Data Protection, General Data Protection Regulation and Confidentiality policy. From April 2022 to March 2023, 90% of staff had completed data protection training.

In 2018 the Information Governance toolkit was withdrawn and replaced with the new Data Security and Protection Toolkit. It was developed by NHS Digital in response to The National Data Guardian's Review of Data Security, Consent and Opt Outs published in July 2016 and the subsequent Government response, Your Data: Better Security, Better Choice, Better Care, published in July 2017.

The Data Security and Protection Toolkit is a tool which allows organisations to measure their compliance against legislation and central guidance, and helps identify areas of full, partial or non-compliance. The assessment summary report for 2022/23, completed by an external audit agency, gave an overall National Data Guardian standard assurance rating classification of 'moderate assurance'. This meant there were no standards rated as 'Unsatisfactory', and 1 or none rated as 'Limited'. However, not all standards were rated as 'Substantial'.

In last 12 months no breaches had occurred that required reporting to the Information Commissioner's Office.

Engagement

People who use services, the public and staff were highly engaged and involved to support high-quality sustainable services. However, given the significant operational and financial challenges facing the trust, greater partnership working is needed.

People who use services, those close to them and their representatives were actively engaged and involved in decision making and their views and experiences were gathered and acted on to shape and improve the services and culture of this trust.

The trust listened and learned from feedback through a range of sources, including engaging with people accessing services, surveys, patient stories, Friends and Family Test (FFT), the Patient Advice and Liaison Service (PALS), through complaints, compliments, external stakeholders and daily contact with people accessing services within the hospital. Feedback provided a valuable insight into people's experiences of care, what matters to patients and the people important to them.

The FFT is a national survey, providing people who have accessed services within the trust an opportunity to provide feedback on how satisfied they are with their experience. A national standardised question is asked:

'Thinking about [the area accessed], overall how was your experience of our service?'

Our findings

Whilst national reporting of the response rate ceased from 1st April 2020, the trust response rate continued to be monitored closely to provide assurance that patients were being provided with an opportunity to provide feedback. A total of 28,704 FFTs were completed and returned during 2022/23.

Of the FFTs completed, 97.7% of respondents rated their experience as very good and good (between April 2022 and March 2023), which was above the target, and comparable to previous years. Current performance was expected to vary between 96.9% and 98.8%.

Digital stories was a tool that enabled an insight of personal experiences of care within the trust. Digital stories were a medium to escalate the voices of patients and people important to them, enabling them to be listened to within board meetings.

A number of digital stories, captured during 2022/23, had been shared through the appropriate channels within the trust. Next steps and actions were developed in response to digital stories to increase awareness and promote learning as a result of feedback. A recent digital story, heard at board in 2023, was able to provide board members with assurance regarding the joint working between a local community health trust and this trust to improve pathways through the work of the 'Virtual Wards'.

People accessing services within the trust were able to record their experience via a third party. These included for example, the Care Opinion and NHS Choices websites and Healthwatch. During 2022/23, 'enter and view' visits had resumed, with Healthwatch visiting 4 areas across the trust. The focus of the semi-announced visits were to speak to patients, visitors and staff about their experiences, with a focus upon communication, nutrition and hydration. General patient feedback identified a number of positive experiences. Feedback had been valuable in supporting improvements across the areas, examples of some improvements made included the appointment of an additional ward clerk to further support communication and telephone response times and the trust and wider system supporting a range of initiatives to improve discharges and reduce capacity pressures.

People's concerns and complaints were listened and responded to and used to improve the quality of care. During 2022/ 23 the trust received a total of 805 formal complaints, demonstrating an increase of 117 in comparison to the previous year (2021/22) and an increase of 217 in comparison to 2020/21.

The trust was required to acknowledge all complaints either verbally or in writing within 3 working days of receipt. This was achieved in 99% of cases during 2022/23; in the 2 cases where the written acknowledgement was late, both patients had received a verbal acknowledgement within 3 working days and a written acknowledgement within 4 working days. The complaints team had set a stretch target of sending a written acknowledgement within 2 working days, this was achieved in 98% of complaints, with 86% of written acknowledgements being sent within 1 working day during 2022/23.

Each complainant was given a timescale for response, which varied depending on the complexity of the complaint and the level of investigation required. Where it was not possible to respond within the initial timescale agreed, the complainant was contacted and advised of the delay and given a new timescale. In 2022/23, 57% of complaints were responded to within the initial agreed timescales, whilst this reflected a slight increase from the previous year by 4%, response rates within the agreed timescale remained significantly below the trust target.

During 2022/23, significant recruitment took place in the complaints and PALS Teams, creating a new structure incorporating succession planning and potential opportunities for future leaders. This had provided an opportunity to review and improve processes, to ensure that they were working as effectively as possible. A new approach had been

adopted within the PALS to increase visibility of PALS Officers across clinical areas, strengthen relationships with clinical teams and increase awareness of the support they offered. The team had spent time visiting clinical areas to deliver education sessions to staff to help raise awareness and to speak with patients and people important to them about any concerns they might have.

Although complaints response rates for the trust overall remain below the expected standard, within 3 of the divisions (Surgery, Anaesthetics and Cancer, Women and Children's, and Clinical Support Services) the standard timescale for response had been reduced from 60 to 45 working days.

The Patient and Carer Experience (PaCE) panel consisted of public and staff representatives who worked together in a collaborative approach towards quality improvement and patient experience within the trust. The panel met quarterly, chaired by the director of nursing, and co-chaired by a patient representative. The panel incorporated patient representatives, divisional representation together with public participation, PALS and complaints, service improvement and communications leads, and external partners from the Maternity Voice Partnership, Healthwatch and Powys Community Health Council. The PaCE panel reported to the board's quality, safety and assurance committee.

Speciality patient experience groups reported into the PaCE panel and led on patient experience improvement initiatives at a local level. The PaCE panel had received updates on a range of priority projects concerning patient experience, examples of these were: the Getting to Good programme, Freedom to Speak Up, Mental Health and Learning Disabilities, Hospital Transformation Programme, Emergency Transformation Programme, national survey results, staff health and wellbeing, the UX System, and feedback from Healthwatch Enter and View visits.

During 2022/23 PaCE panel patient representatives had supported a range of activities, including:

- Speciality Patient Experience Groups
- Patient Information Panel
- Food Focus Group
- Exemplar visits and accreditations
- Establishing an Independent Complaints Review Group
- Letters Workshops
- Letters Task and Finish Group
- Procurement review
- Providing feedback in the form of a digital story
- Equality, Diversity and Inclusion Advocate Group
- Patient Led Assessments of the Care Environment (PLACE)
- Volunteer work within the trust
- Recruitment through participating in stakeholder groups.

Engagement and involvement included people in a range of equality groups it was however, in its infancy. The trust had an Equality, Diversity and Inclusivity Advocate group to help identify health inequalities and drive improvements throughout the trust. A gap analysis of the trust's seldom heard communities had been undertaken and an action plan had been developed with a quarterly update provided to the trust's public assurance forum. Areas of focus for April to

June 2023 included: taking part in Iftar, the breaking of the Ramadan fast, at a Mosque in Telford, meeting with a charity organisation who provided ongoing support and day centre facilities for the homeless and vulnerable in Shrewsbury and attending a wellbeing support meeting, designed to bring together health and wellbeing services for farmers, with the aim of improving their mental health and wellbeing.

Pharmacy was involved with surveying patients for feedback on the pharmacy service as part of a patient experience group.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. This included those with a protected equality characteristic. Staff stories were heard at trust board. These stories valued the perspective of the people sharing their experience, providing a tool through which they could share what was important to them, enabling storytellers through empowering them to tell their story in their own words and in their own way. The stories provided an insight into their experience, offering a different perspective and an opportunity to reflect.

There was transparency and openness with all stakeholders about performance. The trust engaged with the 2 ICSs that covered the surrounding geographical area. Given the operational and financial pressures within the trust, it was important that the system worked together to improve care for people using services and the community. Executives could describe how they engaged with the ICS. We were concerned that actions to help resolve some of the pressures on the trust were not always apparent or happened at pace. On average there were 150 patients on a given day, with no criteria to reside within the trust. This undoubtedly added pressure to the responsiveness of the urgent and emergency care patients received. The collaborative relationship with external partners, with a shared understanding of the challenges within the system to deliver services to meet the needs of the community, was an area still evolving.

The chief pharmacist liaised with other chief pharmacists within the ICS. This ensured there were links for good system working and collaboration. There was joint working on the discharge medicine service with the local pharmaceutical committee for community paediatric services.

Learning, continuous improvement and innovation

Staff described being committed to continually learning and improving services. The trust had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders aspired to continuous learning for their staff and innovation for the trust. The trust was in year 2, of a 5-year Research and Innovation strategy. The trust had a head of research and a deputy director of education and improvement committed to learning, development and quality improvement. The trust received an NHS England research and development certificate in October 2023, that recognised the teams work. The Improvement Hub within the trust aimed to empower staff to have confidence, capability, passion and knowledge, to test changes and make improvements at the trust and community they served.

The trust used standardised improvement tools and methods and ensured staff had the skills to use them. The team had developed a structured improvement method for staff to plan change, test new ideas and measure impact. This methodology had been used to help combat the stigma of breast cancer in some local ethnic communities, where staff had engaged with communities to educate and empower people about their healthcare. All staff had access to quality

improvement training. The Improvement Hub had established training courses that were accessible to all staff across the trust. These included SaTH Improvement Introduction video (15 minutes), SaTH Improvement Fundamentals course (1-day) designed to enable all colleagues to engage with improvement and SaTH Improvement Practitioner course (6 months) designed to enable colleagues to run individual and team improvement projects.

Staff were supported alongside their training by members of the Improvement Hub. Additionally, there were online resources, including the provision of short "Bitesize" videos that covered every topic of the trust's improvement method. As of September 2023, 420 staff had completed the 'fundamentals' course and 60 staff had completed the 'practitioner' course.

New projects and programmes were being looked at to streamline and improve the delivery of pharmacy services and make them more patient focussed. For example, the launch of the Discharge Medicine Service had secured funding as a pilot to support the development. A dedicated team was set up at both sites, however, further development of the IT infrastructure to support the service was required. There had been collaborative working with all providers within the ICS to ensure there were no gaps in sharing information for this new service.

Staff we spoke with were enthusiastic about the on-going improvement project plans. However, many staff feedback that the trust had a very ambitious approach on quality improvement project and almost felt they had too many ongoing projects.

The trust had invested in a purpose built SaTH Education, Research and Improvement Institute, opened in November 2023. This provided staff with an environment for office space, meetings and training focussed on research, education, and improvement. We spoke with junior doctors who told us that they felt supported, and training was prioritised.

The education and improvement staff had contributed to the development of NHS IMPACT (Improving Patient Care Together), a shared NHS improvement approach. The approach aimed to create the right conditions for continuous improvement and high performance, so that systems and organisations could respond to today's challenges, deliver better care for patients, and give better outcomes for communities. The trust had benchmarked themselves against the approach and scored between 2.6 and 3.3, out of 5. Thay had an action plan with next steps to improve their benchmarking scores. The trust had an ambition to obtain university status and were working alongside a local university to achieve this.

Participation and learning from internal and external reviews, including those related to mortality or the death of a person using the service, was effective and robust. In December 2016, the CQC published its report 'Learning, candour and accountability': A review of the way NHS trusts review and investigate the deaths of patients in England. The report identified that there were inconsistencies in the way acute trusts carried out mortality reviews and there was a need to improve learning from deaths reviewed. The national guidance on learning from deaths (March 2017) subsequently provided a framework for NHS trusts on identifying, reporting, investigating, and learning from deaths in care.

As part of this well led inspection, we reviewed examples of 10 serious incidents, we found the investigation reports to be well put together, comprehensive and kept to the terms of reference. We found the trust's processes for reviewing deaths to be robust. The Structured Judgement Review (SJR) process was used to review the care received by patients who had died. This allowed learning and supported the development of quality improvement initiatives when problems in care were identified. Performance was monitored through divisional governance teams, 28% of SJR's were completed in July 2023. Summary data and learning was taken to board quarterly. We found the trust had made significant improvements around processes over the last 2 years, documentation and processes was transparent and fit for purpose.

Our findings

The trust was currently providing training for the new patient safety incident response (PSIRF) framework. PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. The trust triaged all incident through their incident system daily, with the patient safety team reviewing and determine the grade of harm. Serious incidents resulting in moderate and above were reviewed weekly, investigated, and presented to the trusts weekly Review Actions Learning from Incident Group (RALIG) meeting, where the Executive team with a multidisciplinary team approach reviewed the incidents. It was then agreed if the incident should be investigated under the serious incident framework. Families were informed of the outcome from RALIG and invited to be part of the investigation. The agreed timeframe for written response was 60 days, trust had 10 out of 37 over their 60-day target at the time of our inspection.

Executive and non-executive directors regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance. Board members told us, board development days led to improvements and innovation. Recent development days had covered topics such as, board committee effectiveness, risk appetite and board skills review.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Good ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Shrewsbury Hospital	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024
The Princess Royal Hospital	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024	Good ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024
Bridgnorth Community Hospital	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Oswestry Maternity Unit	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Ludlow Community Hospital	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall trust	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Good ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024

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

Rating for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ May 2024	Good ↑ May 2024	Good ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Requires Improvement ↑ May 2024	Good ↑ May 2024	Requires Improvement →← May 2024	Inadequate →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024
Outpatients	Requires improvement Apr 2020	Not rated	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Overall	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024

Rating for The Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024
Services for children and young people	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024	Good ↑↑ May 2024
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Inadequate ↓ May 2024	Good →← May 2024	Requires Improvement ↓ May 2024	Inadequate ↓ May 2024	Requires Improvement →← May 2024	Inadequate ↓ May 2024
Maternity	Good ↑ May 2024	Good →← May 2024	Good →← May 2024	Good →← May 2024	Good ↑ May 2024	Good ↑ May 2024
Outpatients	Good Apr 2020	Not rated	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Overall	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024	Good ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024

Rating for Bridgnorth Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017

Rating for Oswestry Maternity Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017

Rating for Ludlow Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017

The Princess Royal Hospital

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

Description of this hospital

The Princess Royal Hospital is part of Shrewsbury and Telford Hospitals NHS Trust and provides acute services to those living in Telford and surrounding areas.

Services at the Princess Royal Hospital include urgent and emergency care services, emergency medicine and surgery, paediatric services, and maternity and end of life care services. Along with diagnostic and screening, critical care and outpatient services.

The Urgent and Emergency Care service at Princess Royal Hospital (PRH) provides services 24-hours per day, seven days per week service. The hospital is the main receiving centre for the acutely unwell child. The ED comprised of booking in, a main waiting area, a children's waiting area for those aged under 18 years, two triage rooms for adults and two for paediatric patients, a 4 adult resuscitation spaces and 1 dedicated paediatric resus space separate to adults, 8 majors' cubicles, a 4 bed 'pit stop', a respiratory isolation unit, (RIU), that could accommodate up to two patients in separate side rooms plus additional space for patients well enough not to require a trolley. Four minors' cubicles providing care to patients who presented with minor injuries, a fit to sit area; a children's assessment and treatment cubicle, and a "Pit stop" or rapid assessment area for patients arriving by ambulance, or for those patients who self-presented to the ED who were prioritised by nursing staff. The Urgent Treatment Centre is open 9:00-21:00 and do extend their hours in times of extremis.

The hospital's medical care services comprised of cardiology, renal, respiratory and dermatology, stroke, care of the elderly and neurology, diabetes and endocrine, clinical support services, oncology and haematology.

The Palliative and End of Life Care Team provided a service across both the Princess Royal Hospital and the Royal Shrewsbury Hospital. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

End of life care

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff.

At our last inspection in 2021 we were concerned the service was not providing adequate mandatory training modules and subjects. Since our last inspection the mandatory training had improved and now included basic life support, infection prevention and medicine management training. The mandatory elements were repeated once a year on or near the same date where possible. All staff completed an in-depth induction programme.

Staff told us they received protected time to complete training and kept up to date with their mandatory training. They told us they completed their mandatory training, which were a mixture of face-to-face training and electronic learning packages.

End of life care was part of the trust's mandatory training programme. Data showed The Palliative and End of Life Care Team (PEoLC) had an 87.8% compliance rate with mandatory training, with the chaplaincy service at 100%, the hospital porters at 88.39% against the trust target of 90%. A mandatory care after death training video was introduced in October 2022, the compliance rate for this for all nursing and medical staff was 89.52% at the time of our inspection.

The trust used an electronic monitoring system to manage staff mandatory training on a yearly basis. Staff told us they were responsible for making sure that they were up to date with all their training and could access their training records online. Staff were sent reminder emails when their training was due to expire.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) training for all clinical staff was delivered alongside mandatory resuscitation training with attention to all aspects of the ReSPECT process included.

These comprehensive documents recorded patient's wishes in regard to escalation of care (whether they wanted to be admitted to intensive care or remain on ward level care) if their condition deteriorated, their priorities relating to end of life care (for example, symptom control, preferred place of death) as well as the decision of whether they wished to be resuscitated. The ReSPECT form is transferrable across the health economy and when patients were discharged, they took with them the original document.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

The PEoLC did not have a specialist mental health, autistic or learning disability pathway for end-of-life care patients, however, the team told us that they worked very closely with the mental health team and sought advice when needed.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff were alerted when they needed to update their training by the trusts' automatic electronic red, amber and green (RAG) rated flagging system. Staff said if they fell behind with their mandatory training, managers would receive notification of this and would discuss it with them.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Staff who provided end of life care said they had received training in safeguarding children and vulnerable adults. Safeguarding training was part of the trust's mandatory training programme.

The safeguarding training modules included level 1, 2 and 3 adult safeguarding training and level 1 and 2 children safeguarding training, conflict resolution, preventing radicalisation and Mental Capacity and Deprivation of Liberty training.

Safeguarding training rates for medical and nursing staff were reported within the individual directorates. Data showed the PEoLC achieved 100% compliance rate for safeguarding training against the trust target of 90%.

There were up to date, trust wide safeguarding policies and procedures in place, which were accessible to staff through the trust's intranet site. Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise.

There were effective systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

All staff we spoke with had undergone training on the Equality Act as part of their mandatory training and were knowledgeable about the subject.

Equality and diversity were promoted within the trust. Staff, including those with particular protected characteristics under the Equality Act, told us they were treated equitably.

Throughout our inspection, we observed staff were non-judgemental in their approach to the care of patients and families. For example, we observed staff explaining medication to a person who appeared to have minor confusion, this was done using language the person understood and they took extra time to explain the medication in detail and answer questions.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

End of life care

Staff received training specific for their role on how to recognise and report abuse. Staff had good knowledge of how to raise a safeguarding alert and the necessary actions to keep patients safe. There was a clear pathway for reporting and dealing with safeguarding concerns. Staff described the actions they would take if they identified a safeguarding issue; this was in line with the trust policy.

Cleanliness, infection control and hygiene

Staff used infection and prevention control measures when visiting patients on wards and transporting patients after death.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

SWAN is an abbreviation for Signs Words Action Needs, which concerns palliative and end of life care patients.

End of life and palliative care patients were nursed throughout wards at the Princess Royal Hospital which included 11 specified SWAN rooms on wards, the acute medical unit, intensive care unit and in accident and emergency.

The SWAN rooms were dedicated side rooms on most of the wards for patients that are at end of life.

All ward areas we visited where end of life care or palliative care was being provided to patients were visibly clean and tidy.

The cleaning records for the mortuary viewing rooms for both children and adults for the period November 2022 to October 2023 showed an average of 98.12% compliance against the trust target of 90%.

The trust had an up-to-date infection prevention and control (IPC) policy, which provided guidance for staff on the prevention and control of infection. Risks associated with IPC following the death of a patient were contained in the provider’s infection prevention guidelines.

Data showed 100% of hospital porters had undertaken training on IPC against the trust target of 90%.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Throughout our inspection, we observed staff to be compliant with best practice with regard to infection prevention and control policies. There was access to hand washing facilities on all the inpatient wards we inspected.

PPE which included gloves and aprons, was available on all the wards we inspected. There were adequate resources of PPE for all staff to utilise when caring for patients. We observed all staff adhering to the bare below the elbow policy and to good hand hygiene principles (hand washing or hand gelling) after or before patient contact or undertaking aseptic procedures. This was in accordance with the World Health Organisations (WHO) five moments for hand hygiene.

Staff provided care after death to deceased patients on the ward before transfer to the mortuary and were knowledgeable about the procedures to undertake for a patient who died with a contagious disease and would discuss this with the ward manager, IPC team or the staff from the mortuary if they needed further advice or information.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We saw equipment that had been cleaned had a green ‘I am clean’ sticker attached to it.

End of life care

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Clinical waste and domestic waste bins were emptied by the cleaning staff on the ward area and disposed of through the trust's waste disposal procedures. Staff adhered to correct principles for managing and disposing of devices with sharp points or edges that could puncture or cut skin (sharps). Sharps bins were correctly assembled and were not overfilled. All bins were observed to be below three quarters filled.

Patients could reach call bells and staff responded quickly when called.

A call bell system was on all the wards we inspected for patients and care givers to ring when they required assistance from the nursing staff or in an emergency. We observed that when the call bells were activated, staff responded relatively quickly.

Patients told us the staff responded fairly quickly, but it took staff longer to respond during busy times on the ward.

The design of the environment followed national guidance; however, we had concerns about the mortuary viewing glass.

At our last inspection we found the viewing of children within the mortuary called the 'Snow drop room' was not fit for purpose. The room was used as a walk-in fridge, this meant it was not appropriate for families wishing to spend any time with their deceased loved ones, due to the temperature and noise from the refrigeration system.

Since our last inspection, we saw there had been improvements in the viewing of children. The 'Snow drop room' there had been a major refurbishment and at the times of viewing, the deceased would be transferred on a bed with bedding, into an adjacent viewing room with comfortable chairs.

The service had suitable but basic facilities to meet the needs of patients' families,

The visiting deceased adult patients was undertaken by appointment in a separate dedicated room away from the children viewing room and near the mortuary. The room was neutral of religion and people were afforded privacy to pay their respects to their loved ones. The mortuary viewing room was visibly clean, but small and basic. It provided a limited number of seats for relatives only. There was a small waiting room but no other facilities for relatives and loved ones.

We saw that viewing was undertaken through a viewing glass in a locked door from the viewing room should the family and loved ones of the deceased not be allowed to view the deceased in the same room. For example, if there was a coroner's inquest.

We noted the viewing glass was a small square and situated high on the door, this meant that people of average height, would have to stretch to view the deceased, furthermore, there would not be enough room for 2 people to view at the same time. This window was covered by a curtain, as we pulled back the curtain, it came off the rails it was attached to.

The service had enough suitable equipment to help them to safely care for patients.

End of life care

There was sufficient equipment available to meet the needs of people receiving end of life care on all of the wards we visited.

The trust used specialist syringe drivers for patients who required continuous infusion of medication to control their symptoms, and these met the current requirements of the Medicines and Healthcare Regulatory Agency This meant that patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication because the syringe drivers were tamperproof and had the recommended alarm features.

Staff told us they did not have a store of their own syringe drivers, however, if they required one for a patient, staff from the medical equipment library provided them in a timely manner. Out of hours, there was a system for them to access the equipment library to collect a syringe driver. These were readily available and obtained from a trust wide medical device library.

We visited the equipment library and observed there were a large number of syringe drivers which had all been collated and were ready for use. ‘Grab and go’ boxes were available across all wards which contained relevant equipment to make up two syringe drivers.

Additional items of equipment including pressure relieving equipment was readily available for end of life care patients if required as indicated by risk assessments.

Staff carried out daily safety checks of specialist equipment.

The equipment we inspected was fit for purpose. Single-use items were sealed and in date, and emergency equipment was dated to indicate it had been serviced. We saw records showing equipment was checked daily by staff. This meant the equipment was safe and ready for use if required in an emergency.

There were resuscitation trolleys throughout the in-patient wards. We observed these were accessible and had daily and weekly checks and the equipment stored within resuscitation trolleys and grab bags were within expiration dates.

Staff disposed of clinical waste safely.

Staff were aware of procedures for IPC, such as the management of clinical waste and environmental cleanliness. We observed Staff disposing of clinical waste safely, separating general and clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used the National Early Warning Score assessment tool for recording the observations of patients admitted to the hospital. Early warning scores were developed to enable early recognition of a deteriorating patient. End of life care patients were assessed for how regularly observations were required and this was documented in their notes. We looked at one patient record and saw the tool had been used appropriately.

Staff knew how to recognise a deteriorating patient and how to escalate this. We observed nursing staff asking a member of the PEoLC to review a patient who had deteriorated and saw they responded promptly.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff completed regular risk assessments for patients receiving end of life and palliative care. We reviewed 1 set of patient records, which included up to date care plans and risk assessments.

Staff were able to identify patients who were palliative or end of life and carry out a referral to the PEoLC if they needed to. The service had improved how referrals were undertaken by ward staff since our last inspection in 2021. The PEoLC had introduced an electronic referral system in October 2022. These referrals were then RAG rated via the patient pain score and other symptoms management scores to determine how soon the patient would be reviewed. Ward staff could also carry out telephone referrals if they felt it was urgent, these would still be followed up with an electronic referral to ensure it was on the system.

The PEoLC reviewed all patients admitted with a diagnosis of cancer receiving palliative care, and all other end of life patients who required assistance with pain control, had complex needs or who required specialist input to facilitate a speedy discharge home.

There were dedicated end of life care champions on every ward who provided specialist support on a day to day basis.

Staff from the palliative and end of life care team would undertake regular reviews of patients whilst they were inpatients. We saw evidence of these reviews in patient notes.

Staff knew about and dealt with any specific risk issues.

The service undertook intentional rounding. This is an organised process where nurses carry out regular checks with individual patients at set times. During these checks, the nurses would undertake scheduled or required tasks including for example, observations of patients, addressing patients' pain, re- positioning, and personal care needs, assessing, attending to the patient's comfort, and checking the environment for any risks to the patient's comfort or safety. Dependent on the individual patient's level of risk, these checks were conducted between 1 to 4 hourly intervals.

The service had 24-hour access to mental health liaison and specialist mental health support (If staff were concerned about a patient's mental health).

Staff told us they knew how to access the specialist mental health team if they were needed.

There had been no specialist mental health training for staff since before the pandemic. However, the mental health lead was in discussions with the Mental Health Liaison Team (MHLT) who had agreed to recommence a rolling training programme, which would be monitored during joint governance meetings quarterly.

At the time of our inspection, 3 separate dates in November had already been organised for training. The Clinical Lead within MHLT had also developed online training covering the referral process to the MHLT for mental health illnesses and presentations and individualised care planning. Although this training was not mandatory, the trust told us discussions were being undertaken with the education department on making the e-learning part of mandatory training.

Staff shared key information to keep patients safe when handing over their care to others.

Information about end of life and palliative care patients were discussed at the daily handovers and on board rounds.

At the time of our inspection, the trust had recently converted from a traditional do not attempt cardiopulmonary resuscitation (DNACPR) form to a new ReSPECT form.

Data for both hospitals as the trust was unable to separate out for individual sites, showed that 1,106 patients were referred to PEoLC and had a conversation about their preferred place of care or death recorded. For a further 139 patients, after their first assessment, it was assessed that this discussion was not appropriate. 73 patients had active documentation that no discussion took place, but no reason recorded and for 60 patients had no data on their preferred place of care or death recorded. Of all patients, 998 patients were recorded to have achieved their preferred place of care or death.

The trust audited the use of ReSPECT forms across both hospital sites quarterly. For the most recent audit in June 2023. The Princess Royal Hospital site showed a completion rate of 83.70% for the key areas for ReSPECT.

Shift changes and handovers included all necessary key information to keep patients safe.

We attended an early morning handover and saw that incoming staff were updated on the events of the previous shift and key information was shared. Staff would have information as to whether a patient had a ReSPECT form in place, were palliative or were end of life in the handover document. During handovers, staff were made aware of any patients who were at risk, for example, those at risk of falls or those who were confused.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Nursing staffing levels were reported within the individual directorates. Following on from the inspection in 2021 the service made the decision to merge the specialist palliative care and the end of life care teams to create one service. This team worked across both The Royal Shrewsbury Hospital and The Princess Royal Hospital sites.

The service had enough nursing and support staff to keep patients safe. At the last inspection in 2021, nursing staffing levels did not meet the minimum standard of the National Institute for Health and Care Excellence. These standards state access to specialist palliative care should be made available 7 days per week. At this inspection a 7-day palliative and end of life care service had been introduced and embedded.

At our last inspection in 2021, we were concerned that the trust did not have enough staff. The service has since recruited additional nurses. The service had 6 full time band 7 nurses and 2 band 6 nurses (who worked 1.3 whole time equivalent WTE). Staff were managed by the matron for Oncology, Haematology & Palliative Care matron and supported by a band 8a End of Life Care Facilitator.

The service had vacancies for a band 8b team leader to cover the whole service and a band 6 working 0.6 WTE. The Palliative and End of Life Care Team did not use bank and agency staff.

Medical staffing

End of life care

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical staffing levels were reported within the individual directorates.

The service had enough medical staff to keep patients safe. At the previous inspection in 2021 medical staffing levels did not meet the minimum standard of the Royal College of Physicians (RCP), which required 1.4 WTE consultants based on the size of the trust. At this inspection the service had recruited additional staffing and now met the RCP standards. The service had 3 palliative medicine specialist staff who worked an equivalent of 2.2 WTE and one of them was shared with the local hospice.

The service had a vacancy for an additional specialist palliative medicine consultant working 0.8 WTE. Medical staffing levels were reported within the individual directorates.

The chaplaincy team consisted of 1 full time chaplaincy lead, 7 part time chaplains (3.3WTE) and a part time administrator. The chaplaincy service provided a 7 day service across both hospital sites with chaplaincy on-call cover for all faiths and none.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records.

Since our last inspection, the record keeping had improved. A system to aid communication between staff throughout the trust was introduced for patients admitted through accident and emergency and known to the PEoLC. The alert remained after discharge, so that on future admissions admitting staff were made aware of the patient's status. For patients in the last days of life, the trust used a 'SWAN alert' for those patients cared for on the SWAN care plan, this meant staff were aware the patient was receiving care in the last days of life.

We reviewed the medical and nursing notes of 1 patient who was receiving end of life care. The medical and nursing notes were accurate, complete, legible, and up to date.

The record we reviewed included detailed information about the management of symptoms, discussions and interventions. Records were stored securely. Medical and nursing notes were stored securely on all the wards we inspected. There was evidence of consent with regular updates recorded in medical and nursing notes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

End of life care

The service followed best practice and local policy when prescribing, dispensing, delivering, and monitoring medicines given to palliative and end of life care patients which included medicines used in anticipatory prescribing. Anticipatory medicines are medicines which are prescribed for key symptoms associated with last days of life (for example, pain, agitation, excessive respiratory secretions, nausea and vomiting and breathlessness) and are prescribed in advance for rapid symptom relief.

Data received from the trust showed for 2022, anticipatory medication prescribing and review of medical interventions for end of life care patients was completed 75% of the time. However, at the time of our inspection, this had risen to 96% with 1 patient not having the anticipatory medication prescribed, which was addressed during the audit process. Medical interventions rose during the same period from between 70% and 80% in 2022 to 93% for 2023. Medical hydration documentation also improved from 66% in 2022 to 89% for 2023.

Staff completed medicines records accurately and kept them up to date.

We looked at 1 medicine chart for an end of life care patient and saw the anticipatory medicines had been prescribed appropriately and in accordance with best practice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff from the PEoLC told us as part of the ReSPECT process they discussed the patients medicines with both the patient, family, and care giver as appropriate.

Staff stored and managed all medicines and prescribing documents safely and in line with the trust's policy.

The trust pharmacy team and hospice medical team provided prescribing and medicine guidance 24-hours, 7 days a week.

Staff told us that some patients required continuous medication administration through a syringe driver to control their symptoms. At the time of our inspection, we saw that 1 patient required a syringe driver.

Staff were knowledgeable about syringe drivers and the medicines which were usually placed in them. Staff told us some patients required more than 1 due to incompatibilities between some medicines. All staff were required to undergo specific competency training for managing a syringe driver, with a duration of supervised practice prior to being able to lead on this.

Administration of medicines and intravenous fluids to patients was managed safely. All intravenous fluids, medicines and syringe drivers were checked and administered by 2 nurses.

The trust had a detailed medicines management policy which was regularly reviewed, understood by relevant staff and specific to this service. Prescribers had access to local, regional, and national prescribing guidelines relating to medicines used by the trust.

The PEoLC team had 6 WTE Specialist Nurses 4 of whom were experienced non-medical prescribers and one was undertaking training at the time of the inspection.

End of life care

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

The service had systems to monitor and manage accidents and incidents to maintain patients' safety. Staff were aware of the process to report any incidents and accidents.

Staff raised concerns and reported incidents and near misses in line with trust policy. Data showed that between October 2022 and 30 September 2023 there were no Never Events or serious incidents on any wards across both hospital sites at the trust relating to end of life care patients.

The trust told us they had systems to ensure that incidents related to end of life care were learnt from. The trust confirmed incidents were reported through their electronic incident reporting system with a specific flag for patients who were at the end of their life. Incidents were reviewed by the Lead Clinician and PEoLC Team and responded in a timely way.

Staff reported serious incidents clearly and in line with trust policy. All the staff were able to explain how they would identify and report incidents.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers shared lessons learned with staff and the wider service at regular team meetings, electronic communications, and training sessions.

There was evidence that changes had been made as a result of feedback. In the previous 12 months the service had evidence of positive changes they had made following learning from incidents. These included funding travel expenses for relatives who could not afford travel costs to visit their dying relative. The expansion of verification of death training for band 6 and above nurses and hospital at night practitioners in order to improve time taken to complete death verifications. The Palliative and end of Life Care team also put on additional sessions in pain management at continuous professional development events after a series of incidents.

Staff understood the duty of candour. However, they were not able to give examples of where duty of candour had been undertaken within end of life care services.

There was a standard operating procedure which provided guidance to the requirements of duty of candour.

Is the service effective?

End of life care

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Overall, we found that care provided was evidence based and followed recognised and approved national guidance. Staff were clear of their roles in care pathways and were aware of the national guidelines relevant to their scope of practice. For example, we observed staff giving evidence-based advice to another staff member about the anticipatory medicines being prescribed for an end of life care patient.

New policies and procedures were communicated to staff through staff meetings, emails, and weekly updates. All wards we inspected had at least 1 end of life care champion who were able to provide staff with end of life care updates and support. All staff were able to demonstrate they received regular communication from team leaders and above. This meant that staff were able to keep up to date with current practice and national guidance.

We found the trust's end of life individualised SWAN care plans were being used consistently throughout the hospital where patients were identified as end of life to ensure they received evidence based end of life care. Staff were also able to tell us about the current NICE guidance relating to end of life care.

The service undertook an audit of 27 SWAN care plans between 31 July to August 2023 across both sites. The audit showed 100% of the time the person initiating the completion of the care plan entered their signature, date, and time, 70% of the care plans were counter signed by a consultant, 70% of the care plans included information on preferred place of care or death. However, 30% of care plans had no documentation of a preferred place of care or death. A further 96% of patients had all 4 'Just in case' medications prescribed. 'Just in case' medication is also known as 'anticipatory medication', these are medicines which are usually given by injection, and they are given to patients 'just in case' they are needed, for example extra pain relief of medication to help ease nausea. 96% of patients had documentation of the ReSPECT process from the SWAN care plan. However, 1 patient had no documentation of ReSPECT discussions in the care plan, but the ReSPECT form was in place in the notes.

The audit also showed that in 93% of patients, there was a review of their medical interventions documentation, for example blood tests, intravenous treatments, and oral medications.

Staff told us they protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not see any patients subject to the Mental Health Act during our inspection.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

Protected meals times were on all the wards we visited. We observed an end of life care patient had access to drinks, which were within their reach.

The trust used a red tray system when serving meals to patients. A red tray is used on the wards to help staff identify which patients need extra support when eating or need foods that have a modified texture (such as mashed or pureed foods).

We looked at the menu on each ward we visited. The menu had a main section, which included special diets and a vegetarian section. End of life care patients could have any food from the menu including the children's menu. This was to take account of reduced appetites and changing eating habits.

The trust operated a 'Taste for pleasure' system for identified end of life care patients. This was for patients who were restricted with their nutrition and hydration and enable patients whose swallow was compromised to take small amounts of diet and fluid for pleasure rather than keeping them nil by mouth at the end of life.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Fluid balance charts were used to record a patient's fluid intake and output to monitor a patient's fluid balance to prevent dehydration or over hydration for those patients who required a restricted fluid intake. We reviewed 1 patient's fluid balance charts and noted it had been completed correctly.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw the malnutrition universal screening tool (MUST) being used. This is a universal 5-step tool to identify adults who are malnourished, at risk of malnutrition or obese. It also included management guidelines, which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

Specialist support from staff such as dietitians and speech therapists were available for patients who needed it. Staff had access to dietitian services Monday to Friday.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff on the wards also used utilised The Abbey Pain Scale, which is a standardised pain assessment tool developed for use with patients who are not able to verbalise their level of pain, for example some patients who have a learning disability or dementia.

We saw staff considered adequate pain relief for an end of life care patient to be a priority and where needed, they sought guidance and input from the PEoLC.

Patients received pain relief soon after requesting it.

We saw evidence on the intentional rounding chart that nurses regularly checked on the level of patient's pain.

Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to 'when required medication', which was prescribed to manage any breakthrough pain.

Staff prescribed, administered, and recorded pain relief accurately.

We saw that pain was regularly monitored. Assessments had been completed in the patient file we reviewed. The pain chart had been updated regularly and the pain assessment was included in the observation charts.

Drugs were administered by a syringe driver where the oral route had become inappropriate, and symptoms had become continuous.

Staff confirmed syringe drivers were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief.

The trust had a syringe driver tracking system and checklist for when the syringe driver was used for administration of medication. There was a monitoring of infusion section which stated it must be completed on a 4 hourly basis when the syringe driver was in use. Staff told us they did not have a store of their own syringe drivers, however if they required one for a patient, the staff from the medical equipment library were quick to provide them with one.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent, and met expectations.

Managers and staff used the results to improve patients' outcomes. At our last inspection in 2021 we were concerned the service did not have a specific end of life care dashboard to give an overview of quality metrics and key performance indicators. At the time of this inspection the service had developed and introduced this dashboard so it could measure its impact at ward level.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers made sure staff understood information from the audits. The service undertook 'Ask 5' audits which could be undertaken by the PEoLC or by ward managers. These had themed questions which included SWAN end of life care plans, preferred place of death discussions, taste for pleasure, syringe pump driver access and various pain control measures.

The service participated in relevant national clinical audits.

The service had a palliative and end of life care audit and survey work plan, which included a number of audits concerning end of life care. For example, the care after death audit which was undertaken annually and in conjunction with the mortuary to assess and improve quality of care after death and the symptom control audit which assessed pain and symptom control in end of life care patients.

An audit for the use of the ReSPECT forms was undertaken in November 2022 trust wide. The data we received following the inspection showed that a total of 168 patients were identified as having a ReSPECT form across both sites, with 96% of the patients' personal details completed correctly. The date the form was completed was recorded in 93% of cases at The Princess Royal Hospital site.

The summary of relevant information for the plan was also completed in 99% of cases, however the details of other relevant planning documents and where to find them was only completed in 27% of cases overall and the preferred name of the patient was completed on the form 47% of the time.

Managers used information from the audits to improve care and treatment. The dashboard contained all the audit information across all wards at the trust, along with specific training in relation to syringe drivers and end of life care. The PEoLC carried out visits using information from audits to provide targeted support for ward staff. We were provided with examples of specific ward visits across both hospital sites within the last year. We were told that all Improvement were verified and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff joining the PEoLC a full induction tailored to their role before they started work. There was a comprehensive induction programme and supporting framework in place for all newly qualified staff and staff new to palliative and end of life care staff. All staff we spoke with, told us their induction and training was positive and thorough.

Staff received training through e-learning as well as face to face teaching. Staff were positive about the training they received, they told us they had received in-depth training in end of life care from both the hospice and the palliative and end of life care team. Staff told us, they felt competent to undertake their work within the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates were reported within the individual directorates. The rates for the PEoLC were 100%, against the trust target of 90%. Staff told us meaningful appraisals were undertaken regularly and they were positive about the appraisal system.

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being, and capability. All qualified nursing and medical staff we spoke with confirmed they had received a meaningful appraisal within the past year. All staff told us they felt very well supported and competent to fulfil their role.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The trust had suitable provision in place to ensure staff received regular supervision and one to one support. There were systems to ensure nurses and medical staff could meet the requirements for revalidation. Staff were knowledgeable about the trust's clinical supervision policy and the benefits of regular supervision.

The clinical educators supported the learning and development needs of staff.

The Palliative and end of life care team attended and facilitated training. Courses provided included current issues in palliative care, dying matters, and other end of life care aspects. The courses also helped the clinical team to support those champions if they needed emotional support or debriefing. These are sessions that can be attended throughout the year.

End of life care

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they felt supported to pursue additional training to develop professionally. For example, one staff member told us they had been supported to undergo non-medical prescriber training.

Managers made sure staff received any specialist training for their role.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

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

We attended a multidisciplinary meeting and observed all members of the multidisciplinary team worked and interacted well with each other to enable a coordinated approach to the way in which care was delivered. We saw evidence of regular input from the dietitian, occupational therapist, and physiotherapist, involved in the care and treatment of end of life and palliative care patients. Staff worked closely and effectively together with a culture of respect for each other's roles.

In accordance with the Gold Standards Framework, multi-disciplinary meetings took place weekly to ensure any changes to patients needs could be addressed promptly.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff told us they worked in partnership with external providers of end of life care in assessing, planning, and delivering care and treatment. This included the local hospice, GP's, primary care nursing teams, allied health professionals and social care providers. All relevant teams, services, and organisations were informed if people were discharged from the service.

Staff said that patients referred to the PEoLC were seen promptly and reviewed on a daily basis. Since our last inspection, there had been improvements in the triaging of referrals by the PEoLC. There was a new Red, Amber, Green (RAG) rated triage referral system, to ensure those patients in the most need were seen first. There were a number of medical and health issues the triage form covered, for example, pain, nausea, and vomiting. When assessing a referral if a patient was in severe pain, the PEoLC would see the patient within 4 hours. If a patient was in moderate pain, 24 hours and mild pain, 48 hours. However, if the same patient had 2 moderate categories, this would be escalated to a 'Red' review and this meant a response of within 4 hours would be undertaken.

Nursing staff on the wards we spoke to as part of our inspection said the Palliative and End of Life care team always responded promptly within the RAG rated timescales.

End of life care

Data for the period April 2022 to March 2023 across both sites showed that of the 1,378 patients referred to the PEoLC, 421 (30%) were triaged to an urgent 4-hour response time, of these 421 patients, 394 (93.6%) were seen within the 4 hour window.

Board rounds took place on the wards daily where patients who required a fast track or rapid discharge pathway were discussed. The PEoLC told us they had an effective relationship with the local hospice and ensured that patients nearing the end of life were referred to the hospice in a timely fashion as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff told us they knew how to access the specialist mental health team if they were needed on a 24 hour basis. Staff shared essential information to keep patients safe when handing over their care to others and when patients moved between wards or for end of life care patients transferred to the community.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The palliative and end of life care team provided a service from 8:30am to 5:30pm, 7 days per week across the 2 hospital sites. Outside of these hours, there was a dedicated advice line at the local hospice for specialist advice and an on-call consultant accessible via the hospice.

End of life care was provided by general nurses and medical staff on the wards throughout the hospital 24 hours a day. The trust had implemented the SWAN model of care and had recruited and trained end of life care champions. There were between 1 and 4 champions on each ward who attended palliative care meetings and cascaded information to staff at ward level.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could request support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

The chaplaincy service provided pastoral and spiritual support and was contactable out of hours. The multi-faith facilities were available to patients, visitors, and staff 24 hours a day.

The mortuary provided a 24-hour, 7 day a week service to the trust and to the coroner.

Bereavement services were open Monday to Friday and an out of hours service was available for cases at the discretion and availability of the staff on duty. Weekend visiting for deceased children was available through a mortuary on call.

Not all therapies were available 7 days a week.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on wards. We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

End of life care

We found that information leaflets were available on a range of health issues throughout the hospital, and they had produced new ones relating specifically to end of life care to support patients and families. These included information about making Do not resuscitate in the event of cardiac or respiratory arrest decisions; supporting children and young people when someone is seriously ill; the SWAN model of care: and a comprehensive booklet covering all aspects of what to expect when someone was being cared for at the end of their life, which included the practical guidance on what to do afterwards. These were available in different languages on request.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff used the initial assessment documentation.

End of life boxes contained information to support patients and their families across a range of areas, for example, eating and drinking at end of life and supported staff to enable individuals to live a healthier lifestyle.

We saw information support centres in the hospital, offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Patients were encouraged to eat and drink during their stay in hospital and were given a choice of menus to choose from.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Mental Capacity Act and Deprivation of Liberty Safeguards training rates were reported within the individual directorates.

Staff were not always knowledgeable or showed an understanding of how and when to assess whether a patient had the capacity to make decisions about their care.

Nursing and medical staff told us they had received training on the Mental Capacity Act (MCA) and how to complete MCA assessment as part of their mandatory training. Doctors completed the MCA assessments, though nurses and allied health professionals were also trained to do so by the trust. However, not all staff we spoke with were aware of the MCA legislation and how it related to the patient. For example, on ward 9 and ward 15, we saw an MCA assessment on each ward that had been completed retrospectively for a decision around ReSPECT forms. The legislation does not allow for mental capacity assessments to be completed retrospectively, as they must be completed on the day that a decision is made about a person's mental capacity. We escalated this to the ward manager on both wards and when we returned a new mental capacity assessment had been completed which related to the required decision of the patient. We were told that further training in mental capacity assessments and their completion was being rolled out to staff.

We looked at 22 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders across the hospital and found there were inconsistencies in how these were completed. We found that out of 22 DNACPR orders, 2 (10%) were not completed correctly. We found staff had not always followed trust policy when they completed DNACPR orders and ReSPECT forms and they were not completed accurately for the same reason. A lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and or their families and care givers.

End of life care

The trust undertook an audit of mental capacity assessments for both sites for the period December 2022 to February 2023. In total, 40 patient records were reviewed, 20 at the Royal Shrewsbury Hospital site and 20 from The Princess Royal Hospital site were randomly chosen. Findings showed an overall compliance rate of 96% with an overall compliance rate of 100% for Deprivation of Liberty Safeguards completion.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients and relatives told us that staff did not provide any care without first asking their permission. Signed consent forms were evident in most of the patient records we examined and staff clearly recorded consent in the patients' records. All the patient records we looked at, we saw that consent to treatment was obtained verbally and recorded in the nursing care record.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We did not see any end of life or palliative care patients deprived of their liberty during this inspection.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients said staff treated them well and with kindness.

We observed throughout our inspection that staff spoke about the patients they cared for with compassion, dignity, and respect. We observed all staff members speaking to patients and their relatives and care givers with compassion and we observed sensitivity being shown during those conversations.

Staff followed policy to keep patient care and treatment confidential. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. Privacy and confidentiality was maintained throughout their admission. We observed staff drawing curtains around patients when providing personal care, and ensuring any confidential conversations were completed in rooms away from other patients and relatives on the ward.

We saw compassion, dignity, and respect by all staff, including the transfer of the deceased patient to the mortuary. We spoke with the relatives of 1 patient who was receiving end of life care. The relatives described the care and support as excellent and said they felt well informed by the staff.

The mortuary porters told us they always treated the deceased with respect when transferring them from the ward to the mortuary and could describe the process of collecting the deceased from the ward. For example, they would advise the nursing staff they had arrived, the porters would leave the concealment trolley on the landing outside of the ward until the curtains could be drawn around the patients' beds on the ward. This was to promote dignity and privacy.

End of life care

The trust had a bereavement service and staff who provided support for relatives, following the death of a patient. There was a relative's room on most wards where more sensitive conversations could be undertaken. Normal visiting times were waived for relatives of patients who were at their end of life.

The Chaplain told us that they could assist the nursing staff to ensure that care and treatment was provided to patients with due regard to their religious preferences.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

We attended a nursing handover on 1 of the wards we inspected. We observed staff discussing patients with mental health needs. Staff were respectful in their discussions and showed empathy and understanding.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The trust had a comprehensive chaplaincy service, team, and facilities for all faiths and none. The chaplaincy team were very motivated to provide a high level of support for all. They told us they always went that extra mile to help people who were dying and grieving relatives as well as supporting staff.

There was a multi-faith centre within the chaplaincy service where patients, loved ones, relatives and staff could visit. The chaplaincy team were aware of which patients within the hospital who were identified as being at the end of their life and visited these wards daily or more often to offer support. They also offered support to families coping with caring for their loves ones and who were experiencing bereavement and were able to contact any faith leader within the community to provide support in hospital where required.

The chaplaincy service was part of the palliative and end of life care multidisciplinary meetings. Although not licensed to conduct weddings for end of life care patients, the chaplaincy team could facilitate weddings with a community registrar very quickly if required.

Volunteers were used to escort patients to religious services in the hospital or sit with end of life care patients as required. All volunteers received training from the chaplaincy team and were observed in their practice.

Porters told us that ward staff treated the deceased with dignity and respect before they were transferred to the mortuary. Nurses undertook what is known as 'care after death,' this is nursing care performed by nurses to the deceased shortly after death has been confirmed and is the process where the deceased is prepared for transfer to the mortuary.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Family members we spoke with told us they felt involved in the care delivered. We saw staff discussed care issues with patients and relatives and observed a nurse communicating essential information with a patient and their family during a fast-track discharge.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The Palliative and end of life team had recently developed complimentary support boxes, which were offered to families at the discretion

of ward staff. Boxes contained ‘kindness hearts’, these were red, knitted, woollen hearts, 1 was given to the patient and 1 to their loved one. There were drinks vouchers, free parking, support, and advice. All wards we visited were able to provide these boxes. We spoke to relatives of patients who were receiving end of life care, all of the relatives we spoke to told us staff were supportive.

Wards we visited had a relatives room as well as SWAN rooms that staff could utilise for patients who were end of life and their families. Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them.

Bereavement survey results were collated on a quarterly basis. This data was not split to hospital level. Across both hospital sites, the bereavement survey feedback dated September 2023 stated that 83.8% of families felt they were given the right amount of support or more support than was needed during their relative’s end of life care.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

The PEoLC had received training in breaking bad news.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment and staff talked with patients, families, and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were also aware of the trusts complaints process.

The Bereavement survey feedback dated September 2023 stated that 90.4% of families felt they had enough time to ask staff questions. 81% of families also felt they had the opportunity to talk to anyone about any concerns.

Staff supported patients and relatives to make advanced and informed decisions about their care, including preferred place of death. In the 1 record we reviewed, we saw there had been conversations with relatives.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the needs of the local population.

End of life care

At the previous inspection in 2021, the staff did not have a comprehensive system to identify the total number of patients who could benefit from their services, so did not know the level of unmet need in either the trust itself, or the wider community. Since the last inspection the service had introduced an electronic referral system for ward staff and had increased staffing levels within the team, this meant they were able to respond to referrals appropriately and identify the needs of those requiring palliative or end of life care.

At the previous inspection in 2021, the service did not monitor inappropriate referrals. As a result, the palliative and end of life care teams identified the needs of some, but not all, of those requiring palliative or end of life care within the community they served. Since the last inspection the service had introduced a triage system which ensured patients received support in a timely manner and meant that inappropriate referrals could be identified.

Patients were discussed at weekly hospital palliative care multidisciplinary team meetings and daily board meetings. Wards allowed open visiting and relatives could stay overnight.

The trust had no dedicated palliative care wards in the hospital. Nursing staff told us that, where possible, and if appropriate, patients receiving end of life care were nursed in SWAN rooms on dedicated wards to give them and their relatives more privacy and dignity.

Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen. There were also patient and relative information leaflets around the processes involved in caring for patients at the end of life.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had staff members to aid the delivery of care to patients in need of additional support. For example, end of life and dementia link staff, champions and learning disability link nurses.

The chaplaincy team, which included volunteers, regularly visited significant ward areas, such as the emergency department and the intensive care unit and visited all those patients who had been placed on the individualised end of life care plans.

Staff were aware of cultural and religious differences in end of life care and would contact the chaplaincy for advice where required.

SWAN rooms allowed the people important to the patient, to spend time with them in a more peaceful environment. We saw the rooms contained additional items, such as CD players, mood lights, pictures, and reclining chairs. All SWAN rooms we inspected were clean and well maintained.

The trust had 2 concealment covers called X-Cubes. These were three-dimensional frames with a cover which was placed over the deceased on the ward and on the bed in which they had died and were still present, thereby preventing the deceased being transferred to a trolley. This meant that the deceased privacy and dignity during transfer was upheld and that the handling of the deceased by the porters was kept to a minimum.

The service had introduced a complimentary therapy service, a member of staff came from the local hospice to provide treatments to palliative and end of life care patients for 1.5 days a week. This provided moments for relaxation for patients and allowed staff to start conversation around hospice care post hospital admission.

In the intensive care unit, staff told us that patients who were nursed in side rooms, were encouraged to bring their dogs from home to visit them.

Wards were designed to meet the needs of patients living with dementia. Patients with dementia were offered “Butterfly Boxes”, a small finger food box containing small portions of finger food they could eat throughout the day, when assessed as safe to do so.

The service had information leaflets available in languages spoken by the patients and local community. The trust had access to a translation service to meet the needs of those whose first language was not English. Information leaflets could be adapted to braille and other languages and formats as required.

In the critical and intensive care units, all patients had a patient diary called ‘All about me’ completed by staff, family, and loved ones, so that when they left the unit, they would know what had happened as patients often have no memory of the time spent in critical care.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. At the previous inspection in 2021, the trust did not offer a 7 day service, but this had since been introduced and was embedded within the PEoLC. Between 1 October 2022 and 30 September 2023, the PEoLC saw 22% of patients across the trust who died. However, this data also included patients receiving acute treatment and who would not have been a suitable referral. The PEoLC had a target to see all patients within 24 hours maximum. Between 1 October 2022 and 30 September 2023, the PEoLC achieved this for 93% of patients across the trust.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff undertook discharge planning. Patients nearing the end of their life could be referred to a fast track discharge pathway, with a target of providing the patient to their preferred place of care within 48 hours. These discharges were undertaken by the Integrated discharge team who worked 7 days a week. Data showed that between 1 October 2022 and 30 September 2023 at The Princess Royal Hospital, the service had discharged 203 patients with an average of 5.9 days for the discharge to take place when the patient was medically fit to leave hospital. However, the service had difficulties arranging transport for patients from Wales, which we were told led to extra delays.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. For the period October 2022 to September 2023 data was not split to hospital level and was therefore across both hospital sites. The data showed the PEoLC received a total of 1,193 referrals, 746 referrals were for patients with a cancer diagnosis and 450 were for a non-cancer diagnosis. This equated to 63% for patient cancer diagnosis and 37% for a non-cancer patient diagnosis.

There were no specialist palliative care beds at The Princess Royal Hospital site. Patients were cared for on the wards in SWAN rooms throughout the hospital and departments according to their admitting diagnosis.

Managers and staff started planning each patient's discharge as early as possible. The trust engaged with their Integrated Care Board for NHS Continuing Health Care funding to enable some patients to be discharged home using a fast track discharge for those patients who were in the last weeks of life and a rapid discharge for those patients identified to be in the last days or hours of life. Staff told us that some discharges often took around a week but could be achieved more quickly when necessary. Discharges were occasionally delayed by the challenges faced with providing suitable transport.

Staff we spoke with explained that the fast track system was very dependent on the resources available locally and that it sometimes did not happen due to lack of resources in the community. For example, a lack of places at the local hospice. The trust did not audit performance on this process.

Patient records demonstrated an integrated multidisciplinary approach towards meeting patient needs, including offering staff guidance, identifying, and implementing specialist equipment and specialist assessments of care, for example swallowing and mobility aids amongst others and discharge planning.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The PEoLC, nursing and discharge planning teams worked very closely with the mental health team and sought advice when needed.

The PEoLC shared information with the patient's general practitioner (GP), the local hospice and community nursing teams to ensure a coordinated approach to care planning and to meet individual needs and preferences.

The bereavement team liaised with ward staff patients and their families in relation to dying and deceased patients offering support and guidance in significant times of need.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. Staff knew how to raise concerns or make a complaint on behalf of a patient or their relatives. Staff told us if a patient or relative had concerns about the care being delivered, they would try and address the issue at the time in order to resolve the concerns as quickly as possible.

Staff understood the policy on complaints and knew how to handle them. The trust had an up-to-date complaints policy. The policy was available for staff to access on the trust's intranet. The policy and procedure provided guidance and standards for the handling of complaints. Relatives told us they would feel comfortable raising a complaint with ward or the complaints service if necessary.

The service clearly displayed information about how to raise a concern in patient areas.

There were posters in ward areas which told patients and their representatives how to make a complaint and information on the trust website.

Complaints would be handled in line with trust policy. Staff told us they would advise patients to go to the patient experience team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.

Managers investigated complaints and identified themes.

For the period October 2022 to September 2023, data across both sites, (the trust did not provide data separated to individual hospitals) showed there was a total of 60 complaints and 84 compliments for the PEoLC.

The themes identified included recognising dying, communication with patient and families during dying and the ReSPECT process.

We were told as part of our inspection the trust clinical leadership was aware that improvements in the ReSPECT process were required and this was discussed at the Quality Operational Group after it emerged as a theme with the monitoring of PEoLC complaints. A working group was set up with representation from divisions and Learning from Deaths and Resuscitation teams as well as the PEoLC. Since the working group was implemented, a clinical lead role for ReSPECT was in the process of being developed.

Is the service well-led?

Our rating of well-led improved. We rated it as good.

Leadership

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

The service had a clear leadership structure. A non-executive director and the director of nursing, midwifery and quality held overall leadership responsibility for end of life care and specialist palliative care services.

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff in the palliative and end of life care team spoke positively about leaders and the support they received.

End of life care

The overall team was cohesive and more connected. At the previous inspection in 2021, mortuary, chaplaincy and bereavement service staff did not feature on the schematic diagram provided to CQC to explain the service's leadership structure, and bereavement services sat under a different management structure. The existing PEoLC Steering Group has been strengthened with representation from key stakeholders across the Trust including mortuary, chaplaincy , bereavement services and the quality team alongside the PEOLC team.

Leaders were aware of and could articulate the current issues faced by the service and had undertaken a large programme of work since the last inspection to manage these issues and improve the service.

PEoLC staff we spoke with said they felt valued by their manager and support was available at any time should they need guidance in their respective role.

Leaders in the service had the right skills and abilities to run the service. Leaders within end of life care and palliative care services received management training when entering into their new leadership roles. Managers told us they felt well supported by the Surgery, Anaesthetics and Cancer management team above them.

Leaders were visible to the teams and supportive. Staff described leaders as supportive and accessible. Staff told us they were encouraged to develop and take on more senior roles. Managers across all teams operated an open door policy.

Staff on the wards were aware of the PEoLC.

There was board oversight of end of life care services. The PEoLC reported to the board through the scheduled care team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Since our last inspection, we saw there had been improvements with the end of life care strategy. The trust had created a new Palliative and End of Life Care Strategy for 2023-2026, which they were in the process of launching at the time of this inspection. The strategy document set out the commitment of the trust that people nearing the end of their life would receive high quality care and would be supported to live well and die with dignity in their place of choosing.

The strategy set out 10 aims underpinned by sub-assertions. Progress against the strategy was monitored through the Operational trust's Palliative and End of Life Care Steering Group, which includes non-executive director with monthly updates to trust committees.

The trust had adopted the SWAN scheme, a national model of care and an acronym for signs, words, actions and needs in the care of the dying.

We noticed that wards and departments throughout the hospital had information displayed on a dedicated board for staff to refer to about the SWAN initiative, the end of life care champions, useful links and contacts, and other relevant information.

End of life care

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The trust promoted the culture that care of the dying was everyone's responsibility. Staff told us that they felt they provided high quality palliative care to patients and were supported by the PEoLC and the champions. Staff spoke passionately about their priority for providing end of life care for patients.

Ward staff were focussed on the needs of the patient's receiving palliative and end of life care. Ward staff felt well supported by the palliative and end of life care team. At the previous inspection in 2021, end of life care was not a tangible priority on wards. Ward staff were not fully engaged in making dying everyone's responsibility. This was reflected in the fact that in more than 1 area, staff did not recognise patients under their care as end of life or palliative, even when prompted. There had been a lot of work undertaken by the palliative and end of life care since the 2021 inspection. Ward staff we spoke to were clear about their responsibilities and we could see ward staff providing good care to palliative and end of life patients.

Staff within the PEoLC told us they felt valued and respected. The service had an open culture where patients, their families and staff could raise concerns without fear. Palliative and end of life care team staff told us they could raise concerns openly with leaders.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders had improved the governance services across the trust. There were several areas which were identified during the last inspection in 2021 and leaders had actioned these issues and concerns and improved the services.

Staff had clear opportunities to meet and discuss the service with clear objectives. At the previous inspection in 2021 governance around the palliative and end of life care steering group was inconsistent. At that time, the service was also not effectively auditing the palliative and end of life care service to measure the quality and performance. The agenda did not state who was chairing, whether the meeting was quorate, and had no regular space for mortuary staff to input or provide updates. Since that inspection the group has expanded and now included representatives from the palliative care team along with mortuary, chaplaincy, and bereavement service representatives. The group had introduced clear and defined terms of reference. The group produced a quarterly report for the Quality Operational Committee (QOC) and an annual written report of its activities will be produced and presented to the steering group, QOC and the Quality and Safety assurance committee.

As part of the inspection process, we reviewed the meeting minutes between February and September 2023. The minutes clearly demonstrated that the terms of reference were being followed, every meeting was quorate and included a review of the previous actions. Each meeting included a case presentation, a review of the dashboard, learning, patient feedback, divisional reports, and audits. Actions were clearly identified and had staff assigned to them.

The service worked with partner organisations. Since the last inspection in 2021 the service had introduced and signed a service level agreement with their local hospice to provide mutual support to help both services. This agreement ensured that the hospice provided a consultant-led, on-call, out-of-hours telephone advisory service for palliative care.

End of life care

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders identified relevant risks and issues within the service. Similar to the previous inspection in 2021, the team did not hold their own separate risk register and it sat within haematology where there were 3 open risks at this visit. At this inspection, we could see evidence of risks being discussed at PEoLC steering group meetings and being added to the risk register as a result.

The risks listed were risks to End of Life Care Service as a result of shortage of specialist consultant input, delay in patient transfer from ward to SWAN bereavement suite and devices inappropriately being left in patients when received by funeral directors. Risks were RAG rated and had clear evidence of being reviewed on a regular basis.

Leaders and teams used systems to manage performance. The service had the dashboard system in place to monitor end of life care performance at ward level. This was then used to target specific areas on wards in order to drive improvement in performance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used reliable data to monitor performance or quality. At the previous inspection in 2021, the service did not have any systems to give an overview of quality metrics and key performance indicators and could not measure its impact at ward level. At this inspection, the service had developed and introduced a dashboard so it could measure its impact at ward level. The information was accessible and allowed staff to provide targeted support to specific wards for specific risks.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The PEoLC engaged well to meet the needs and requirements of their patients and families and celebrated the good working relationships with the families they cared for. We saw evidence of where patients and families had thanked and praised staff for their care.

We saw examples on the wards where staff had been involved in making positive change. For example, all of the staff we spoke with were able to identify their end of life care champions and told us they felt they communicated well with them.

The end of life care champions provided ongoing, on-the-spot advice and information to staff caring for patients every day. They kept a visual display of information on wall mounted boards on each ward and were committed and motivated to ensuring the vision and strategy were being delivered ‘on the ground’.

The service distributed a sensitively worded feedback questionnaire to bereaved relatives of patients who have died at the trust. Quarterly and annual reports were shared through palliative and end of life care steering group and feedback metrics were reported on the dashboard.

The chaplaincy team were part of the multi-disciplinary team who worked in end of life care and supported patients, families and staff as required.

The trust encouraged all staff to attend end of life care events and conferences which were funded by the trust.

All staff we spoke with told us they felt the PEoLC was a supportive team. Staff interacted in a supportive way within the team to ensure safety and efficiency for patient care and that there was a positive working environment and culture within the team, even during very busy periods.

The trust contributed to the wider system end of life care group and collaborated closely with local end of life care providers, for example commissioners and local hospice providers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. As mentioned throughout the report, leaders and staff had made several improvements across the service since the inspection in 2021. It was clear that staff understood quality improvement methods and had the skills to use them.

The service had created and rolled out a care after death training video. The video was produced by the palliative and end of life care team and the communications department following findings from the audit programme. The video was designed in such a way in could be watched just prior to delivering care after death for the ward staff who did not undertake this very often.

The service had introduced a red, amber, and green (RAG) rated system which helped identify patients in need of a more rapid review and treatment which included a severe score which indicated a patient needed to be seen within 4 hours. It also meant all referrals were handled on a consistent basis.

The service had introduced palliative care review sticker notes to improve consistency in reporting within patients' records. These were seen to be in use across both hospitals and all wards we visited.

Maternity

Good

Is the service safe?

Good

Our rating of safe went up. We rated it as Good.

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

Staff received and kept up to date with their mandatory training. Information received after the inspection showed in September 2023 there was an overall compliance rate of 92%, which was above the trust target of 90%. This was an improvement from the compliance rate at the time of the last CQC inspection.

Staff completed training in fetal monitoring annually. Completion sat between 96% and 100% for all eligible staff groups, consistently above the trust target. The requirements for Fetal Monitoring training for all medical staff had not been set on the database due to technical issues within the system. The education team ensured all medical staff were booked to attend fetal monitoring training and where compliance was not met, a process for escalation to the medical director was in place.

There was additional training for staff who had been identified as requiring further training, following an incident for example. Identified staff were removed from intrapartum care until compliance was met, which was typically within a few days.

Clinical staff completed practical obstetric multi-professional training (PROMPT) electronic learning as part of their mandatory training programme. PROMPT is a standardised course covering practical training scenarios such as management of obstetric emergencies. As of 6 October 2023, compliance rates were recorded as over 96% for all staff groups apart from 88% for anaesthetists, which was just below the trust target of 90%. In addition to this, staff completed face to face maternity inter-professional scenario training (MIST) to enhance the learning from PROMPT.

The mandatory training was comprehensive and met the needs of women, birthing people, and staff. Staff spoke positively of the mandatory training programme. Most training was delivered by e-learning with some face-to-face training available. The face-to-face mandatory training had recently been amended to include 2 parents who have used the service over the last 12 months.

Clinical staff completed training on recognising and responding to women and birthing people with mental health needs, learning disabilities and autism. Specialist midwives provided additional training to staff on mental health and cognitive impairment and staff told us they were accessible for advice when required.

There was an enhanced maternity care and training package, which was a master's level course. This included a competency package involving attendance to critical care where students were supernumerary. In addition to this, the service provided away days for staff learning, and further development opportunities such as enhanced critical care in pregnancy and childbirth. The service had been recognised for exemplary practice by NHSE for this implementation.

Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training. The service piloted a digital application which was further rolled out across the trust. This facilitated audits for individual compliance and allowed managers to track completion.

Compliance reports for mandatory training identified all staff whose training was due to expire within the next 3 months, and those whose training had expired. The data was shared with senior leaders as part of their governance process, so the senior leadership team had oversight of the service compliance. The education team had responsibility for maintaining an oversight of compliance data. They provided or acquired additional training which was beneficial for staff and implemented ways of learning to meet staff needs. However, the overall training compliance was kept and updated corporately by the HR business partner. Managers had the responsibility for contacting those staff who were non-compliant to formulate an action plan for completion with realistic timeframes.

Ward managers were required to review the database for training compliance for their clinical areas on a regular basis and report to the head of midwifery as part of their performance review meetings. Where staff were not compliant with training, the ward manager met with the individual to discuss how training compliance could be improved.

Ward managers and matrons were notified of any non-attendance at training days by the education team and rebooked the training following a discussion with the individual staff member.

The manager of the day was also notified of any non-attendance at training days as soon as the register had been taken and was responsible for immediate follow up of the reason for non-attendance with the individual.

Bank staff compliance was not reported on the monthly report and ward managers were responsible for ensuring all staff working within their clinical areas were compliant with training prior to booking bank shifts. This had been escalated to the senior leadership team and managers had been asked to provide names of any bank staff working in their clinical areas, for compliance reporting.

Managers covered mandatory training as part of the annual appraisal. Staff completed skills and drills training regularly, which was a significant improvement since the last inspection. The core competency framework version 2 requirement for reporting of attendance at in situ simulation had been updated in the July 2023 guidance document. This stated: ‘At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all the scenarios have to be based in a clinical area’.

The maternity specific training guideline had been updated to align with the core competency framework version 2 (NHSE 2023) and had been approved through the relevant governance processes. It was available on the trust intranet and a further review was planned to take place in preparation for the next training year commencing August 2024.

The education team had developed multiple study days covering a variety of topics such as PROMPT, saving babies' lives, resuscitation, fetal monitoring, and personalised care. The process involved developing videos and engagement from Maternity and Neonatal Voices' Partnership.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Staff told us they followed maternity safeguarding guidelines and had attended safeguarding training, which was part of their annual mandatory training requirement.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The maternity safeguarding team received an alert when a referral was made. The team reviewed all referrals to ensure staff followed the correct process and they were available for support.

Staff had a clear understanding of when they would need to report safeguarding issues and who they would contact if they had any concerns.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff were trained to identify female genital mutilation as well as child sexual exploitation and were able to provide examples of how they safeguarded vulnerable women or birthing people, including victims of adult trafficking.

A specialist mental health midwife liaised with the mental health team to safeguard women and birthing people with mental health issues. Staff captured any previous history of mental health worries at the antenatal clinics and escalated to the safeguarding team.

Staff were able to describe 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 emergency duty social work team.

Social Workers met regularly with the safeguarding midwife team to discuss individual cases, policies and procedures, lessons learned and to ensure information was fully communicated between professionals and the appropriate action undertaken.

Women and birthing people were given the opportunity to raise any concerns confidentially with the midwife when on the ward, during clinic appointments or by contacting them by telephone.

Midwifery staff received training specific for their role on how to recognise and report abuse. As of 6 October 2023, the trust's 90% training completion target for safeguarding adults and children training was met for midwifery staff and for medical staff.

Training compliance rates for safeguarding adults were between 95% and 99% for levels 1 to 3, compliance for safeguarding children's levels 1 to 3 were also above the trust target between 96% and 100%.

Safeguarding children level 3 became mandatory for midwifery staff in February 2021. The training compliance for this module at the time of this inspection had significantly improved and was at 100% for level 3 and 94% for level 3 specialised.

Medical staff received training specific for their role on how to recognise and report abuse. The trust provided data which showed compliance rates for medical staff in obstetrics and gynaecology as this was not split. This showed 100% compliance for senior medical staff against 50% for junior medical staff. Service leads told us that due to a technical issue with the system, not all junior medical staff were showing as compliant, however, the medical director had oversight of this and any that hadn't been completed were booked.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensured care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women or birthing people with protected characteristics. For example, 1 staff member told us of a woman who had history of domestic violence, this was identified at booking and actions were implemented to support her through her pregnancy and birth.

Staff followed the baby abduction procedures in the trust's new-born security policy. The service used an electronic baby tagging system to alert staff if a baby was attempted to be removed from the department. Staff regularly tested the alarm system was working effectively. The system was not used if parents did not consent but staff told us this rarely happened. We saw this was on the risk register along with some mitigating actions.

Staff undertook baby abduction drills. At the time of our last inspection baby abduction drills were not carried out routinely and were not included in the maternity specific skills drill scenario training. However, when we asked staff during this inspection, we were told they had them regularly and we were provided with the log of drills which had been carried out.

Staff described the trust's midwifery safeguarding team as visible, and they helped staff to raise concerns. They had amended the leadership of the team from a midwifery leadership to corporate which meant they were aligned with the corporate safeguarding team, particularly with the children's safeguarding team, to ensure they all had a coordinated approach.

The safeguarding midwife shared learning from safeguarding referrals with maternity staff in the weekly safeguarding newsletters and during safeguarding training. They ensured safeguarding referrals information was easily accessible to staff on the trust's intranet and displayed on posters on the wards.

The service had low numbers of women or birthing people with Female Genital Mutilation (FGM). An obstetrician in the service led on FGM and supported the safeguarding midwife to provide training to staff.

Cleanliness, infection control and hygiene

The service managed infection risks well. Staff used equipment and control measures to protect women, birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The service performed well for cleanliness. Hand hygiene audits were consistently 100% between April and October 2023 across all areas.

Training compliance rates for all midwifery and medical staff were 100% for infection, prevention and control (IPC) training. We saw that all areas of the maternity department were clean and well maintained.

The daily tap flushing schedule for the last 12 months showed this had been completed every day, including the midwifery led unit which had variable compliance rates at our last inspection. This was carried out to prevent water-borne infection, such as Legionella from thriving.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff had fully completed cleaning checklists for the previous 3 months, which we reviewed. Following the inspection, the service provided cleanliness audits for the last 6 months. These showed compliance consistently above 98% across all areas, with many demonstrating 100%.

Staff followed infection control principles including the use of personal protective equipment. Alcohol hand gel was easily accessible, and most staff had their arms bare below the elbows in line with the trust's IPC policy. This ensured staff effectively washed their hands to reduce the risk of spreading infections.

Hand sanitising and handwashing facilities were easily accessible with handwashing posters clearly displayed prompting staff, women, birthing people and visitors to wash their hands.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after each patient contact and equipment was labelled to show when it was last cleaned. The use of 'I am clean' labels was consistent across all areas of the maternity service which meant staff knew when equipment needed cleaning or was safe to use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mainly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women and birthing people could reach call bells and staff responded quickly when called. Obstetric emergency drills were carried out on each area of the maternity unit.

The design of the environment followed national guidance. Staff carried out daily safety checks of specialist equipment, and weekly checks of emergency equipment which was used less frequently.

The service mostly had suitable facilities to meet the needs of women and birthing people's families. There was a dedicated bereavement room on the delivery suite for parents to stay following the loss of their baby. This was sympathetically decorated and had facilities for parents to stay overnight to remain close to their baby for as long as possible. There was a separate entrance so bereaved parents could avoid using the main corridor. The bereavement suite was on the delivery suite in line with the recommendations from the Stillbirth and Neonatal Death (SANDS) charity, it followed the national bereavement care pathway, however it was not soundproofed. The Trust had introduced mitigation to reduce any potential noise that parents may hear.

The service leads spoke at length regarding the measures they had considered to improve the environment for bereaved families. They had considered soundproofing and sought external advice, however, this was not possible. As part of the hospital transformation there were plans for a dedicated bereavement suite to be located at the Royal Shrewsbury Hospital site. As an interim measure, if there was a bereaved family in the room the corridor was closed off and rooms around it would not be used. This eliminated any sound from labouring women, birthing people and babies. In the event, that the unit was under extreme demand, they would only use the rooms in the vicinity for women or birthing people who were for monitoring and not in labour.

The Wrekin midwifery led unit (MLU) had 3 birthing rooms, 2 had birthing pools and could be sectioned off when using the pool to feel less clinical, with different light options for a calming feel. The rooms also had a pull-down double bed for parents to lay with their babies as a family after birth.

The service had enough suitable equipment to help them to safely care for women, birthing people and babies. Each birthing room on the delivery suite had a rescusitaire (emergency baby resuscitation equipment) and access to digital

systems to write intrapartum records. In addition, staff could easily access emergency equipment and blood products which meant there was no delay if a woman required a blood transfusion in an emergency. At the time of our last inspection, MLU staff did not have access to digital systems in the birthing rooms on the MLU. This had been resolved by the time of our visit and digital access was available throughout the service.

Staff had access to equipment to remove women or birthing people from the birthing pools in an emergency. Staff conducted drills to practice this.

Staff disposed of clinical waste safely. Staff segregated general and clinical waste and disposed of sharps including needles safely, in line with national guidance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration, however, audits had shown staff had not always escalated them appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS) to identify if a woman's condition was deteriorating and needed increased observations or immediate escalation to medical staff.

The service had a planned audit of the recognition of the severely ill woman on their forward plan This audit had only just commenced at the time of the inspection so there was no data for them to share. We requested some further assurance of the safety of deteriorating women and birthing people, and they shared their achievements and challenges. The challenges had an action plan in place which had been completed and they had achieved improvements. For example, within the antenatal period, a MEOWS assessment was fully or partially completed in 98% of cases. Within the immediate post-delivery and inpatient postnatal period, a MEOWS assessment was fully or partially completed in 100% of cases. Within the postnatal community period, a MEOWS assessment was fully or partially completed in 93% of cases. When MEOWS assessments were undertaken by support workers any MEOWS of 1 or more was escalated to the midwife in 100% of cases. In cases where MEOWS was calculated as 4 or more, a doctor was contacted to review them in 100% of cases and a fluid balance chart was either commenced or continued in 100% of the cases.

The Deteriorating Adults and Maternal Collapse guideline was ratified at Maternity Governance Committee in August 2023 and training had been implemented prior to this within all clinical areas.

Regular cardiotocography (CTG) meetings were now held to discuss and share learning. A CTG measures a baby's heart rate and monitors the contractions in the womb (uterus). Maternity staff reviewed CTG's with consultants and learned from incidents where CTG interpretation was incorrect. Fresh eyes checks were performed every hour for continuous fetal monitoring.

CTG monitoring for women and birthing people was carried out in line with guidance. In the notes we reviewed on site, we found all women and birthing people had CTG monitoring completed appropriately, and staff said they felt confident in reviewing the traces and escalating when required. All documentation around the CTGs (including start and finish times, indication and 'fresh eyes') had been completed.

'Fresh eyes' is a term to describe the process when a second healthcare professional reviews the fetal heart rate trace with a colleague to reinforce good practice and help with decision making. This is done to mitigate against the potential of adverse outcomes in labours where intermittent auscultation is used to monitor fetal wellbeing.

The service provided the result of their most recent fresh eyes audit which showed 92.4% compliance against a 90% to 100% compliance target, in line with Clinical Negligence Scheme for Trusts (CNST) requirements. CNST is a maternity incentive scheme which supports the delivery of safer maternity care.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Records showed staff conducted risk assessments appropriately at booking, following birth and at every admission.

During the inspection we found that when the triage waiting area was at capacity, women or birthing people were asked to wait in another room nearby. However, these women or birthing people were not routinely monitored which meant women or birthing people could be at risk of deterioration without staff being aware. Women and birthing people who were asked to wait in the room were low risk, with a 'green' score and advised to go back to triage if they felt any worse. We raised this with the senior leadership team, and they implemented a new process immediately, where support staff were assigned to check on those women and birthing people and update them on wait times.

The Triage Assessment Cards in use in the Triage Unit were based upon a nationally recognised, published and recommended system to support obstetric triage to ensure a woman is correctly triaged according to her need.

Carbon monoxide screening compliance, which is part of the 'Saving Babies' Lives 2016' was 93% at the time of the inspection. Since the inspection, data showed compliance had further improved to 98% which is significantly higher than the national target of 80%.

Staff were accurately recording fetal growth in antenatal appointments from 24 weeks onwards. This ensured that if there were any concerns identified with the growth of the fetus during these appointments, staff could appropriately escalate.

Staff knew about and dealt with any specific risk issues including sepsis and venous thromboembolism (VTE). The maternity department had a sepsis guideline, which was reviewed and in date. Sepsis is when the body has an unusually severe response to an infection. Staff received sepsis training as part of their maternity specific PROMPT. This included an assessment to test staff knowledge. Sepsis screening tools had been updated since our last inspection to ensure they were suitable for staff to identify sepsis of women, birthing people and babies and the service audited data to evidence they were complying with the recommended sepsis pathway timelines, such as women and birthing people receiving antibiotics within 60 minutes.

Staff completed VTE assessments in line with service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. The service recorded the overall individual VTE results for each area of the trust, including maternity. The "maternity observation management," part of the electronic record was a mandatory field and ensured every woman had a VTE assessment, which we saw when we reviewed women and birthing people's records.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. This meant staff could access specialist mental health support for women and birthing people when needed. A consultant psychologist and a specialist perinatal mental health midwife provided women and birthing people with psychological support.

The service worked well with local mental health providers to support women and birthing people with mental health difficulties following pregnancy loss or trauma. Staff explained how they completed or arranged psychosocial assessments and risk assessments for women or birthing people thought to be at risk of self-harm or suicide. Staff now checked every woman's' risk of domestic violence status during every appointment. This was clearly recorded in the patient records and flagged on the electronic patient record system. Specialist support was available if a woman was at risk of domestic violence and required intervention. The maternity service had links with domestic violence charities to signpost women and birthing people for additional support.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women, birthing people, and babies safe.

Staff discussed all inpatients at the midwifery handover and the multidisciplinary team shift handover meetings. This ensured midwives and medical staff remained up to date about all women, birthing people, and babies.

If any woman deteriorated and required urgent treatment, the service had a dedicated lift directly to the delivery suite.

Staff were trained in baby abduction drills, post-partum haemorrhage drills (PPH) and had emergency PPH trolleys. All women and birthing people had PPH risk assessments, and we saw these were completed when women or birthing people had significant blood loss during the intrapartum phase of pregnancy. Staff escalated appropriately and actions taken to review women and birthing people and mitigate any risks were taken promptly.

Midwifery staffing

The service had challenges with staffing levels to keep women, birthing people, and babies safe, but the oversight of this was a priority. **Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction to keep people safe.**

Actual staffing levels for all areas of the maternity department regularly met the planned staffing and the midwife to birth ratio was 1:24 at the time of our inspection, which was better than the recommended 1:28 provided by the Royal College of Obstetricians and Gynaecologists.

Although there was an improved workforce position, the numbers were impacted by the unavailability of staff, which was increasing. There was a significant number of staff taking maternity leave (16.6 WTE). Long term sickness absence was significant, with an increase in unavailability currently at 21.7 WTE, which combined with the number on maternity leave, was a deficit of over 15% of the clinical workforce. The team were proactively managing this, they had over recruited to midwifery vacancies by 10 WTE in order to provide cover for unavailability due to maternity leave. Uncovered shifts were filled by existing staff undertaking bank shifts.

Service leads told us this unavailability was impacting on the day-to-day operational service delivery within the maternity unit and the senior leadership team were frequently required to enact the midwifery escalation policy to support safe staffing.

During the inspection in July 2021, we identified actions the Trust should take to ensure they comply with its legal obligation that they actively assessed, reviewed, and appropriately escalated any staffing concerns . The service used a nationally recognised tool (Birthrate Plus) to calculate the number of midwives required to provide safe care and treatment to women and birthing people using the service. They also used this tool to monitor acuity and calculate midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives.

Managers accurately calculated and reviewed the number and grade of midwives, woman services assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of women and birthing people. Managers had oversight of the triage unit and the day assessment unit staffing. The service leads had worked on their workforce planning and had recruited significantly since the last inspection.

Weekly staffing meetings were in place to focus on a 2-week forecast, which provided a further opportunity to identify hot spot areas and action appropriate solutions to maintain safe staffing levels.

Each month the planned versus actual staffing levels were submitted to the national database and NHSE, using the information provided from the rostering system and reported monthly to the maternity workforce meeting.

The service used bank staff where required to reduce staffing deficits and always managed to fill shifts without using agency staffing. They always secured staff who were familiar to the service/ward area and with the right qualifications, skills, training, and experience to keep women and birthing people safe from avoidable harm.

The service had significantly improved vacancy rates for midwives and women's support assistants which showed +6.56 whole time equivalent (WTE) for bands 5-7 midwives, 0 for woman service assistants and +6.56 WTE overall. The service attributed this to a more proactive approach compared to the reactive approach they were demonstrating previously.

The service had appointed 10 internationally recruited midwives. They had also appointed 9 midwifery apprentices. Three commenced work in September 2023, with a further 3 each year, along with plans to continue this long term. The midwifery support worker apprentice programme was also in place from September 2023 with 6 recruited along with an apprentice midwifery sonographer.

Other roles which had been successfully recruited into included an equality, diversity and inclusion midwife, breast feeding initiation lead midwife, breastfeeding support midwife, frenulotomy lead midwife, multiple pregnancy midwife, guideline midwife and transformation matron.

The maternity leadership team had joined both regional and national working parties and webinars to ensure the most up to date measures were in place to support staff back to work.

The service had a retention lead to oversee recruitment and retention. They had plans to improve staffing levels through further international recruitment, return to practice, offering advanced clinical practice, leadership development, workforce transformation and an increase in student midwifery university placements.

The turnover rate was significantly below the trust target for all staff groups except for midwifery management at 64%, however, this department had a whole new structure with a number of staff members moving into new and development roles which affected the data. All staff groups were between 3% and 5% against the trust target of 13.1%.

Managers made sure all bank staff had a full induction and understood the service. Managers gave new staff a full induction tailored to their role before they started work. The managers, practice development team, lead professional midwifery advocate and clinical educators supported the learning and development needs of staff and addressed any performance or development issues.

The theatres and recovery bay on the delivery suite were staffed by the main theatres. An on-call team of scrub nurses and operating department practitioners were available for the planned elective lists. Another theatre team was on standby in case the second theatre needed to be opened in an emergency.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment, managers could access locums when they needed additional medical staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women, birthing people, and babies safe. The medical staff matched the planned number. For the last 6 months, consultant obstetric cover was met for all shifts.

The service always had a consultant on call during evenings and weekends. They operated a tier 3 rota system for obstetric medical staffing, which meant there was 24/7 on-site consultant presence as opposed to a consultant being on-call from home. At the time of our inspection there were 13 tier 1 (ST1-ST3), 16 tier 2 (ST4-ST8) and 19 tier 3 (consultant). We reviewed the tier 1 and 2 rotas and found there had been no rota gaps in the last 6 months. However, there were gaps within the tier 3 rota which had required the use of agency locums.

Managers could access locums when they needed additional medical staff. The service had a comprehensive locum induction package that set out the requirements for all locums to undertake both PROMPT and fetal monitoring training prior to working clinically to reduce the risks to patient safety.

Although the service had ongoing rota gaps within the tier 3 rota, 2 locum consultants had been appointed. The service leads told us the provision of obstetric care was always prioritised given it was the acute service, however, this meant there were gaps created within the gynecology service as elective care was cancelled to release capacity to support obstetrics.

Junior staff we spoke with felt well supported and supervised by senior medical staff. The service had low turnover rates for medical staff.

Sickness rates for medical staff were low. From April to September 2023, the sickness rate was 0.56%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In the event of high activity and/or inadequate staffing, senior staff followed the maternity escalation policy to assess whether staffing levels met the acuity of women and birthing people. They redeployed staff to where they were most needed.

During our inspection we observed theatre procedures and saw there were enough staff and an adequate skill mix. We saw some good practices in theatre such as considering emotional needs and adapting language when women or birthing people were members of staff. The team worked well together with respectful relationships and clearly defined roles.

Records

Staff kept comprehensive records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and available to all staff providing care.

Since our last inspection, the service had moved over to a digital records system. We reviewed 20 sets of records, and found they were detailed, and staff could access them easily. Staff used electronic records when caring for women, birthing people, and their babies, except for some women and birthing people, who were still to be migrated to the electronic system. Quality audits were carried out and work was still in progress while the service was in the early phase of the electronic system.

We did not find any concerns within the documentation which we reviewed, or the standard of the triage assessment records. Staff consistently documented the timings within women and birthing people's notes of when they arrived and when they had been triaged. They also documented the triage category women and birthing people were allocated, which identified the actions required in terms of any escalation.

When women or birthing people transferred to a new team, there were no delays in staff accessing their records. Staff told us the community midwives had changed the system which they used for their documentation. The electronic system they now used contained all details about a woman's antenatal history which staff within the acute setting had access to.

Electronic records were always stored securely, we did not observe any computers left logged on with details visible. Any paper records were kept in locked trolleys.

Medicines

The service had systems and processes to prescribe, administer, store and record medicines.

Staff followed systems and processes when safely prescribing, administering, storing, and recording medicines.

We checked 15 medicine charts and saw staff recorded medicines accurately and records were up to date.

Medicine charts were accurately recorded with what had been administered. Patients' weights were recorded on medicine charts, which was important to determine the correct dose of certain medicines.

Medicine allergies or sensitivities were recorded on all medicine charts reviewed. This ensured staff were aware to prevent the prescribing and administration of medicines causing allergic reactions.

Medicines advice and supply from pharmacy was available 5 days a week (Monday to Friday) and staff knew the routes to obtain medicines outside of these hours if required.

A Patient Group Directions (PGD) policy was available. PGDs allow certain healthcare professionals, such as midwives, to supply and administer prescription only medicines without an individual prescription. The PGD policy had been reviewed and was in date.

Staff reviewed each woman's medicines regularly and provided advice to women, birthing people, and carers about their medicines. Pharmacists reviewed patients' prescribed medicines. We saw all medication, including controlled drugs, were stored securely (medicines requiring more control due to their potential for abuse).

Medicines required in an emergency were available. They had a tamper evident seal to ensure they were safe. Staff recorded weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted, or they moved between services. Pharmacists checked and reviewed patients' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns, by following the trust incident reporting policy. Staff told us they received updates about errors or incidents. Staff were able to explain about some recent medicine incidents and the learning that had been undertaken.

The service ensured women and birthing people's behaviour was not controlled by excessive and inappropriate use of medicines. We had no concerns over the use of medication used to control a woman's behaviour. Staff provided women and birthing people with prescribed medication for known addictions. Where women or birthing people had known behavioural conditions, staff administered medication as prescribed.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared the lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. Staff knew what incidents to report and how to report them. Staff reported incidents through the trust's electronic reporting system. Midwifery and medical staff understood their responsibilities to raise concerns and to record safety incidents, concerns, and near misses.

Staff at all levels could clearly explain how to report an incident on the trust's incident reporting system. The escalation in the maternity services policy outlined the responsibility for the manager of the day to submit an incident report when staffing levels fell below standard requirements. We saw evidence of this which showed occurrences and mitigations that were implemented.

Good practice and positive feedback received from families was included on the trust's incident reporting system, this ensured positive feedback and learning was communicated directly with staff.

Managers shared learning about never events with their staff and across the trust. Incident feedback meetings were held to discuss learning from recent incidents. Learning was shared with staff at ward safety huddles and team meetings.

Staff understood the duty of candour. Duty of candour is a regulatory duty that 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate, or prolonged psychological harm. Staff could access the trust's duty of candour policy on the trust's intranet for guidance.

Staff were open and transparent and gave women, birthing people, and families a full explanation when things went wrong. Staff were able to describe their legal obligations under duty of candour and were aware of when they would be required to act upon this.

The total number of incidents reported for September 2023 was 112 which was a decrease over previous months.

Rates of Post partum haemorrhage (PPH) of 1,500ml or greater were in 3.6% of deliveries for September (and 4% year to date), which was higher than the national average of 2.5%. PPH was a consistent theme over the last 12 months. Every PPH over 1,500mls was reviewed in the weekly incident review meeting and those requiring further investigation were escalated to the Divisional Oversight and Assurance Group. We saw all PPH incidents in September were graded as low or no harm, however, this grading was not always appropriate because it was graded on the basis that there were no omissions in care, rather than considering the actual physical or psychological harm to the woman.

The service still reviewed incidents based on causation, which led to some incidents, such as graded tears and shoulder dystocia, being graded as low or no harm. However, the incident management process in the trust, at the time of the inspection aimed to ensured that all incidents were reviewed locally within the Divisions through their local Incident Review Meetings, such as the Maternity Incident Review meeting which was held weekly. The Patient Safety Team reviewed all incidents that were sent for closure/final approval. This independent view of an incident provided a safety net, as if the level of harm had been graded inappropriately the incident would be brought to the weekly Corporate Rapid Review meeting where the multidisciplinary team would review and work with the Division to amend level of harm if felt appropriate. If an incident was then upgraded to moderate or above, the Patient Safety team ensured that the appropriate duty of candour was completed, where appropriate and the incident was escalated to Review, Action and Learning from Incidents Group (RALIG) to consider further investigations.

At the time of the inspection, the service was moving over to the Patient Safety Incident Response Framework which is the new framework for the NHS for responding to patient safety incidents for the purpose of learning and improving. The new framework in the maternity service was implemented in December 2023. All incidents went through a daily triage process where the harm was reviewed, and the narrative of the incident report was reviewed to ensure the narrative matches with the harm.

All overdue incidents were overseen by the governance team, who provided support to matrons and ward managers to undertake timely reviews. The governance team met with delivery suite managers weekly to review, action or close low-level incidents in addition to the weekly incident review meetings. At the time of our inspection there were 67 incidents overdue. The governance team were working across all areas to reduce this, however, capacity within the team had been a challenge and this had impacted on the timely management of some incidents.

Staff were knowledgeable about what constituted a serious incident, and they were able to describe the types of situations they would expect to report.

Staff received feedback from investigation of incidents, both internal and external to the service. Each area of the maternity department had a clinical governance board which displayed learning including good practice identified from incidents and serious incidents.

The perinatal mortality review tool (PMRT) group included representation from other NHS organisations, to provide external scrutiny and oversight of the trust processes. At the time of our last inspection the service was receiving support from several external organisations in both clinical practice and incident management to provide an additional level of scrutiny. The service was also sharing their learning and service improvements with other trusts nationally.

Staff met to discuss the feedback and look at improvements to patient care. Senior leaders had implemented changes to improve safety for women, birthing people, and their babies in response to learning from incidents. Learning was identified from the incidents reviewed and fed back, including through staff huddles and ‘3-minute brief’. Learning was also shared with the education team to be shared to staff through mandatory training.

Maternity

When an incident was identified, we found managers investigated incidents. Women, birthing people, and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Incident reviews also highlighted good practice points to ensure staff were aware of where they had performed well and in line with national guidance.

In 2021, MBRRACE-UK **(**Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) found there were notable increases in stillbirth rates for babies born to mothers from the most deprived areas (from 4.29 per 1,000 total births in 2020 to 4.69 per 1,000 total births in 2021), and for babies of Black ethnicity (from 6.42 per 1,000 total births in 2020 to 7.52 per 1,000 total births in 2021), leading to widening inequalities. As a result, MBRRACE-UK launched their Perinatal Confidential Enquiry: A comparison of the care of Asian, Black, and White women who have experienced a stillbirth or neonatal death.

The trust was aware of this and had started monitoring incidents, along with other measures, by ethnicity and deprivation. A GAP analysis was developed based on the confidential enquiry and any themes or trends identified were explored by the equality, diversity, and inclusion (EDI) midwife and the quality governance team.

The EDI midwife monitored staff training for all staff groups working within the maternity service, on cultural competence and perinatal health inequalities. There was ongoing work implementing quality improvement, addressing health inequalities following a GAP analysis of the Black Maternal Health Report and the Gypsy, Roma, and Traveller Communities Maternal Health report. This included recommendations and areas identified including pain relief.

Telford and Wrekin were identified as an area with 26% of the population affected by indicators of multiple deprivation such as income, education, barriers to housing, poor living environment, health and crime. For women and birthing people accessing the service it had been identified that there were asylum seekers with multiple protected characteristics as defined by the Equality Act. Quality improvement initiatives and alternative models of care were being explored by the consultant midwife to target and benefit women from the most deprived communities.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women and birthing people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies relating to the maternity service and found these were all up-to date and reflected national guidance. All staff had access to national guidance on the trust’s intranet.

Maternity

There were trust wide guidelines for the care of women and birthing people with mental health problems, those with substance misuse and alcohol dependency, homelessness, teenage mothers or complex social factors. A risk and needs assessment including obstetric medical and social history was carried out, to ensure that each woman had a flexible plan of care adapted to their own requirements for antenatal care.

As a result of MEOWS audits carried out and findings that escalation wasn't always implemented, the service created a new guideline, Conflict of Clinical Opinion and Clinical Escalation.

The guideline supported clinicians concerned about an evolving clinical situation or deterioration to be able to escalate and resolve conflicts of opinion effectively. The document defined clinical escalation, who to consider escalating to and summarised the escalation process via a 'Clinical Escalation flowchart.' The 'Clinical Escalation flowchart,' summarised the key steps and techniques to support effective escalation. The techniques were part of the Each Baby Counts Learn and Support Clinical Escalation Toolkit (RCOG 2022a).

Medical staff attended weekly cardiotocography (CTG) meetings to ensure staff were adhering to agreed practice. The trust worked to the International Federation of Gynaecology and Obstetrics (FIGO) initiative on fetal growth: Best practice advice for screening, diagnosis, and management of fetal growth for CTG interpretation. Service leads told us their decision to follow FIGO was to support the understanding of the physiology behind the fetal heart rate patterns seen.

Staff protected the rights of women and birthing people subject to the Mental Health Act and followed the Code of Practice. We observed multidisciplinary handover meetings and found that staff routinely referred to the psychological and emotional needs of women, birthing people, their relatives, and carers. Effective systems of communication were clearly established between all team members and each discipline. Where appropriate, staff would refer or signpost women and birthing people for further support. The service also had specialist midwives to cover a variety of holistic needs who would be involved with a woman's care if required. These included fetal monitoring midwives, bereavement midwives, continuity of carer lead, infant feeding lead, saving babies' lives lead, digital midwife, maternity mental health midwife and antenatal screening midwife.

Staff discussed the previous shift activity, any incidents, safeguarding, bed capacity, medical and midwifery staffing and agreed a summary of each patient to be handed over to the next shift, which was presented by the intrapartum matron or ward manager.

Key messages and lessons learnt from incidents were discussed with staff during handovers, ward meetings, newsletters, and safety huddles.

The handovers included the importance of being sensitive to the needs of women, birthing people and their families. There were multiple handovers and huddles each day including 7.15am delivery suite coordinator handover, 7.30am for midwives, 8.30am for medical staff and 3.15pm for the managers' huddle.

Nutrition and hydration

Staff gave women and birthing people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for religious, cultural, and other needs.

Staff made sure women and birthing people had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff and women or birthing people using the service were all complimentary about the food which was available. The service could meet the needs of all dietary requirements and cultural or religious requirements. In addition to this, staff provided additional provisions, such as tea and toast in between set mealtimes when women or birthing people required this.

Infant feeding midwives supported women and birthing people with their feeding choice for their baby. Staff stored expressed breast milk and baby formula milk safely.

Staff fully and accurately completed women and birthing people's fluid and nutrition charts where needed. These records were stored on the electronic observation recording tool. We did not observe any woman requiring this type of observation during our inspection. Specialist support from staff, such as dietitians and speech and language therapists were available for women and birthing people who needed it. However, this was not a common requirement within the service.

Pain relief

Staff assessed and monitored women and birthing people regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women and birthing people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women and birthing people we spoke with all confirmed their pain had been well managed.

Women and birthing people received pain relief soon after requesting it. We observed this during the inspection.

We reviewed 15 medicines charts, which were all recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to drive improvements for women, birthing people, and their babies, however the use of steroids antenatally was significantly lower than the national average.

The service participated in relevant national clinical audits. The maternity service at the Princess Royal Hospital participated in the National Neonatal Audit Programme 2022 (NNAP). This audit referred to the number of babies (with a final discharge from neonatal care within The Princess Royal Hospital neonatal unit between 1 January 2022 and 31 December 2022). The NNAP uses routine data collection to report on a range of care processes and outcomes throughout the pathway of neonatal care**,** from antenatal interventions to follow-up of developmental outcomes after discharge from neonatal care. Results for the 2 measures relevant to the service showed:

There were 52% of mothers that were given a complete course of antenatal steroids. There were 52% of mothers that were given a complete course of antenatal steroids. 52% was significantly higher than the saving babies lives care bundle minimum ambition target of 40% evidencing the service was working towards the stretch target set within saving babies lives of 60%. This identifies the Trust continuing to improve following the 2022 NNAP report data which showed a national average of just over 50% with the Trust achieving almost 60% at the time.

There were 86% of mothers that were given magnesium sulphate in the 24 hours prior to delivery. This was higher (better) than the saving babies lives minimum ambition of 80% - the service was working towards the saving babies lives stretch target of 90%.

Maternity

The NHS Patient Survey Programme collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS trust between 1 February and 28 February 2022. The trust's maternity service achieved a response rate of 46%, which was around the same as the national average.

There were 51 questions asked in the survey, of those the service performed about the same compared to most other trusts for 45 of them. They performed somewhat better than expected for 4 and better than expected for 2.

The questions where the service performed better were 'Thinking about your stay in hospital, how clean was the hospital room or ward you were in?' and 'At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?'.

The service also participated in the MBRRACE perinatal mortality surveillance, which reports on stillbirths, perinatal deaths, and infant deaths. The report published by MBRRACE in September 2023 was based on births between January and December 2021. This reflected our findings from our last inspection; however, the service had driven changes and improvements in the service since that time which showed a much-improved picture.

All still births, maternal deaths and neonatal deaths were investigated and reported to MBRRACE. Staff reviewed and discussed deaths in their service during regular mortality monitoring and perinatal mortality review meetings. We reviewed minutes from those meetings as well as the data provided by the trust which showed significant improvements. All the learning action plans had been implemented and disseminated through the maternity governance process.

In 2023 the service reported 7 stillbirths and 6 neonatal deaths, this was a reduction from 2022 where there were 14 stillbirths and 12 neonatal deaths. At the time of our inspection, there was one case under investigation by the Health Services Safety Investigations Body (HSSIB), the last HSSIB recommendation following an investigation was in April 2022.

The service had recruited a lead specialist midwife for audit which had enabled them to have a comprehensive audit programme at the time of this inspection. We saw audit outcomes were aligned to the governance process which meant senior leaders were better able to monitor the outcomes for women, birthing people, and their babies. Outcomes for women and birthing people were mostly positive, consistent, and met expectations. Managers and staff used the results to improve women and birthing people's outcomes. The service used the maternity clinical dashboard to report on and monitor a range of indicators for the service. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. This allowed the service to benchmark their performance against other similar services in addition to enabling the service to target reviews and improvements at the appropriate parameters.

Managers and staff investigated outliers and implemented local changes to improve care. They monitored the improvement over time. The trust was supported by external organisations to ensure improvements were sustained and became well embedded.

Managers shared and made sure staff understood information from the audits. The service was effectively using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard. Improvement was checked and monitored.

Maternity

The Shrewsbury and Telford Hospital NHS Trust had received 2 Independent Reviews of maternity services in the past 18 months. The first Ockenden report was published in December 2020, and the final Ockenden report, in March 2022. The reports contained 210 actions in total for the trust to implement without delay. These reports highlighted significant failings at the trust's maternity services and the impact this had had, and continues to have, on the families concerned. The trust told us they were committed to learning from their experiences. Improvement work was ongoing with the aim of achieving the highest standards of maternity care and rebuilding the confidence and trust of the community. The service continued to implement actions contained in the first report, along with all new actions from the final report. At the time of our inspection 124 of the 158 actions from the final report had been completed.

Competent staff

The service made sure staff were competent for their roles. Most staff had received their appraisal or supervision meetings to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women and birthing people. Support staff and newly qualified midwives were on a rotation programme, so they were able to experience all areas of the service to better understand each area's challenges and for better relationships between wards. This was to enable a more flexible and skilled workforce who would be able to cover any areas when staffing challenges were experienced. This was also seen as a potential to strengthen the skills staff already possessed as well as potentially developing their skills further. Any additional training and upskilling was available from the education team.

We were told that it would take 5 years for all to fully rotate as each member of staff spends time in a supernumerary role in every area until they feel confident and competent.

Managers gave all new staff a full induction tailored to their role before they started work. Newly registered midwives were also entered on to the trust's preceptorship package. The programme included competency assessments in perineal suturing, cannulation, venepuncture, Cardiotocography (CTG) interpretation (electronic monitoring of babies during labour) and medicines management. New maternity support workers also had competency packages to support their development and learning.

Managers supported most staff to develop through yearly, constructive appraisals of their work.

Most staff had received an annual appraisal. The trust set a target of 90% completion. As of October 2023, 84% of midwifery staff and 90% of medical staff had received their annual appraisal.

The education team supported the learning and development needs of staff. The service also had 7 professional midwifery advocates (PMAs) who supported staff. PMAs supported staff with reflections post incident, with coronial inquests, meetings with managers, requesting additional training and many other aspects where staff required some support. The service provided unannounced 'skills drills' training which gave staff real life scenarios played out to develop their performance in such situations.

Team meetings were consistent across the areas within the service and staff spoke positively about the range of information that was shared to enable them to provide care and treatment to meet the needs of the women, birthing people, and babies. We were told the managers encouraged staff attendance or ensured staff had access to full notes when they could not attend. To ensure staff were not left without vital updates, information was shared with staff through other communication methods including workplace social media groups, emails, and newsletters.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. At the time of our last inspection, we found some difficulties with staff being released from their areas if completing more formal education or training sessions. Staff told us due to gaps in staffing, they had been disadvantaged in their training requirements. During this inspection we saw a significant increase in staffing and training, which had made a positive impact, staff were provided with protected time for training and further development.

All staff we spoke with said there had been a significant change in the training opportunities within their roles and they felt the leadership team now encouraged staff to take time out to enhance their training and competencies.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The service had several specialist midwives who were able to provide in house awareness training.

Managers identified poor staff performance promptly and supported staff to improve. There were clear processes for staff to follow when staff were identified as underperforming. Senior leaders discussed examples of where they were managing challenging behaviour. Medical leaders also had oversight of the locum medical staff who worked within the service to ensure they met the expected standards.

Multidisciplinary working

Doctors, midwives, and other healthcare professionals worked together as a team to benefit women and birthing people. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The maternity service promoted multidisciplinary team working, which included antenatal services, midwives, midwifery support staff, health visitors and social services. Daily communication with local GPs and community midwives ensured good working relationships were maintained between all staff. Women or birthing people with complex social needs were referred to the local social services team.

We observed a morning handover meeting on the delivery suite, antenatal and postnatal wards where staff discussed all women and birthing people on the ward and those scheduled for admission. Handovers included all necessary information to keep women, birthing people, and babies safe.

Staff referred women and birthing people for mental health assessments when they showed signs of mental ill health or depression. Staff referred women and birthing people for mental health assessments to the local mental health trust if they presented with mental ill health or would contact the specialist mental health midwife for advice and guidance.

Staff could refer women and birthing people to the bereavement midwives as well as the chaplaincy service. There was a multi-faith chaplaincy service and a small chapel within the hospital, which we saw several members of staff using for prayer throughout the duration of the inspection.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff with different roles worked together as a team to provide holistic care to women and birthing people. We saw staff were respectful of one another and all staff we spoke with said they worked well together as a team and fully involved women, birthing people, and their families during their stay.

Maternity

Seven-day services

Most key services were available 7 days a week to support timely care. However, a lack of radiology capacity was impacting on timely neonatal hip scans.

Consultants always led daily ward rounds on all wards, including weekends. Women and birthing people were reviewed by consultants depending on the care pathway. We were told there were consultant led daily ward rounds on the delivery suite 7 days a week.

The delivery suite was open 24 hours per day, 7 days per week. The maternity triage line was available 24 hours a day, 7 days per week, which was covered at all times by dedicate triage staff.

The triage unit was covered 24/7 by the on-call team of doctors consisting of a resident consultant, tier 2, and tier 1 doctor. There was an additional tier 2 doctor or consultant who was assigned to triage from 8am to 7pm, 7 days a week. In periods of escalation the tier 2 or consultant assigned to cover the gynaecology service could be called for additional support. Midwifery staffing was available 24/7.

The day assessment unit was appointment based and open 7 days a week between 9am and 5pm.

Woman service assistants ran a postnatal clinic 7 days a week for simple checks and observations.

Staff could call for support from doctors and other disciplines, including mental health services and most diagnostic tests, 24 hours a day, 7 days a week.

Service leads told us the lack of radiology capacity was impacting on waiting times for neonatal hip scans. This meant babies requiring neonatal hip scans may not be scanned within the 4 to 6-week national standard. To mitigate this the service were checking daily to identify babies who required hip scans. The screening midwife was checking when babies had an appointment for a scan and any baby who was identified as not having a hip scan appointment was followed up with radiology. All outcomes following hip scans were recorded by the screening midwife.

If there was a safeguarding concern, staff would contact the out of hours emergency duty social work team for advice and guidance.

Health Promotion

Staff gave women and birthing people practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Mothers were supported to initiate breastfeeding postnatally in hospital and when discharged home.

We saw a large amount of information and literature which women and birthing people could access to promote a healthier lifestyle.

Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, women and birthing people were asked about their smoking status at their booking appointment, were offered smoking cessation support and could be referred to a smoking cessation service.

The trust website contained information about breastfeeding, weight loss, and the importance of a healthy diet.

Maternity

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women and birthing people to make informed decisions about their care and treatment. They followed national guidance to gain women and birthing people's consent. They knew how to support women and birthing people who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women and birthing people's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff showed good awareness of the procedure to follow regarding the Mental Capacity Act 2005 and the importance of informed consent. All staff we spoke with were aware of the mental capacity legislation and how this related to women and birthing people. Staff told us how they would involve women and birthing people as far as possible and those close to them and other relevant professionals such as social workers in making a best interest decision which considered the patient's wishes, culture, and traditions. However, none of the staff we spoke with on the delivery suite could remember a recent case where a mental capacity assessment had been undertaken.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us they provided as much information as possible before gaining consent. Verbal consent was gained between the woman and midwife during examinations and the recording of observations. This was confirmed by the records we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff told us they had experienced a few situations where relevant legislation was applicable and were knowledgeable in their application. If, however, they were not sure, they were able to advise how and to whom they would escalate the situation for guidance.

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Data provided by the trust during the inspection showed as of September 2023, staff that had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for medical and midwifery sat on or above the trust target of 90%.

Managers monitored the use of Deprivation of Liberty Safeguards and staff we spoke with knew how to access the policy on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The trust policies were available on the intranet for staff to access. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

If staff had any concerns or questions in relation to this, they would contact the safeguarding midwife for support, advice, and guidance. However, staff in maternity services were seldom required to complete a deprivation of liberty safeguards application for women and birthing people.

Is the service caring?

Good

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

Maternity

Compassionate care

Staff treated women and birthing people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women and birthing people. Staff took time to interact with women, birthing people and those close to them in a respectful and considerate way. Staff always ensured when providing care and treatment to patients, curtains or doors were closed to maintain the privacy and dignity of women and birthing people. Staff demonstrated caring approaches to women and birthing people throughout our inspection, and in all areas. All women and birthing people we spoke with gave overwhelmingly positive feedback on their care and treatment from all maternity services.

Women and birthing people said staff treated them well and with kindness. Staff introduced themselves to women and birthing people when they provided care. Women and birthing people were informed of care that was being provided and what to expect next, for example, we saw an antenatal plan of care was fully and clearly explained.

We observed staff to be skilled in communicating with women, birthing people, and their families. All the interactions between staff, women, birthing people, and their families were caring, positive and informative. We saw women and birthing people were listened to and involved in their care.

We observed staff treating patients and any relatives with kindness and compassion. Within the triage unit, staff especially demonstrated compassion and kindness towards the women and birthing people attending, many of whom were in an upset and anxious state.

Staff followed policy to keep women and birthing people's care and treatment confidential. Staff were aware of the requirement to maintain patient confidentiality. Staff lowered their voices when discussing any concerns with colleagues as well as when discussing any details over the telephone with a patient. Staff ensured no patient identifiable information was displayed within public view.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women and birthing people with mental health needs. All women and birthing people we spoke with told us they felt respected by staff, and staff were very caring towards them. Where women or birthing people were known to have additional and complex needs, staff appeared to be considerate of this and treated all women and birthing people well.

Staff understood and respected the personal, cultural, social, and religious needs of women or birthing people and how they may relate to care needs. We observed staff treating all women and birthing people well, regardless of any cultural, social, or religious needs, and with respect, kindness, and compassion.

Emotional support

Staff provided emotional support to women, birthing people, families, and carers to minimise their distress. They understood personal, cultural, and religious needs.

Staff gave women, birthing people and those close to them help, emotional support and advice when they needed it. Staff told us women and birthing people were monitored for their health and wellbeing at all stages of the pregnancy and following birth. Assessments for anxiety and depression were recorded throughout their care.

Bereavement counselling from the 2 bereavement midwives was available for staff to refer women and birthing people to if they required emotional support following the loss of a baby.

The midwifery bereavement team supported all women and birthing people who had experienced the loss of a baby. Women, birthing people, and their families who were undergoing a termination of pregnancy from 12 weeks where their baby had been identified as having a congenital malformation were cared for on the delivery suite. Women or birthing people suffering a miscarriage were cared for on the gynaecology ward until 16 weeks.

The service had a dedicated self-contained bereavement room where staff could take parents to offer them time to come to terms with the loss of their baby. The service had cold cots which allowed families additional time to spend with their baby.

The service provided parents with a choice of memory boxes from several infant loss charities to best suit their requirements. In addition, staff gave parents who were staying in the bereavement room self-care kits which included toiletries and snacks.

Referrals were made to the bereavement midwives either by email or verbally. The bereavement midwives had gained counselling skills as part of their midwifery training. Occupational health support and the chaplaincy service were available for midwives and all staff requiring emotional support.

Staff supported women or birthing people who became distressed in an open environment and helped them maintain their privacy and dignity.

On the delivery suite, women and birthing people were placed in individual rooms with the door closed. Staff followed policy to keep women and birthing people’s care and treatment confidential. We saw that women and birthing people’s privacy and dignity was maintained whilst they were on the unit.

The chaplaincy service worked closely with the bereavement midwives to provide emotional and spiritual support for women, birthing people, and their families.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them.

The service could access the “Lighthouse” service which is provided by the local Mental Health Trust, and provides support to women and birthing people who required additional and specialist support from a counselling psychologist following any type of birth trauma which included delivery complications and infant loss. The Trust had a specialist midwife who worked alongside this service.

The midwifery bereavement midwives worked with the local children’s hospice to support and provide palliative care for families.

Understanding and involvement of women, birthing people and those close to them

Staff supported and involved women, birthing people, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women, birthing people and those close to them understood their care and treatment. Information was available in different languages for women, birthing people, and families whose first language was not English.

Maternity

Staff talked with women, birthing people, families, and carers in a way they could understand, using communication aids where necessary. Women and birthing people confirmed that all staff explained information, particularly complex medical information in a way they could understand. Staff gave them the opportunity to ask questions.

Women, birthing people, and their families could give feedback on the service and their treatment and staff supported them to do this.

Women and birthing people gave positive feedback about the service. The service took part in the Maternity Friends and Family Test (FFT), which asks women and birthing people to rate their experience as "very good", "good", "neither good nor bad", "poor", "very poor" or "don't know". We reviewed a range of the maternity FFT and found scores were consistently over 90% in all areas and generally scored slightly better than the England average. We found 100% of all responses from the FFT in June and 96% in July 2023 were positive and showed users would recommend the service to their friends and family. The Maternity and Neonatal Voices Partnership shared feedback via their 'Thank you Thursday' posts on social media.

Staff supported women and birthing people to make advanced and informed decisions about their care. Staff included birth partners in the planning for the birth and during post-natal care. Staff encouraged women and birthing people to use the Personalised Care and Support Plan to ensure their preferred birth choices were recorded. We saw the 'Your Birth Preference' charts were used by women and birthing people throughout their pregnancies, this chart was then transferred to a large, wall mounted, whiteboard version in the delivery room during labour. The 'Your Birth Preference' chart had images and wording for clarity which women and birthing people could mark to indicate their preferences, including minimal talking, use water, low lighting, skin to skin and breastfeeding. This meant all staff could easily see what the woman's preferences were and did not need to ask or go through notes. Women and birthing people could update these as often as they chose. This initiative was recognised with an award nomination in 2022 and has since been adopted by several other Trusts.

The service encouraged the women and birthing people who used the service to engage with other organisations, such as the maternity and neonatal voices partnership (MNVP). We saw information regarding the MNVP around the unit. The service shared with us a range of compliments they had received through the MNVP. For example, 'I had a high-risk pregnancy which was so well managed through antenatal appointments. Thank you for making me feel so safe.' And 'I had a previous traumatic birth and the staff I saw this time around couldn't have been more determined to give me a positive experience.'

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

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

Maternity

Managers planned and organised services, so they met the needs of the local population. Women and birthing people were able to attend antenatal appointments at the location which was closest to their homes. However, as the Royal Shrewsbury Hospital and the Bridgnorth, Ludlow and Oswestry community maternity units remained closed to inpatients, women and birthing people sometimes had to travel further to the Princess Royal Hospital to give birth. The service had promoted home births as an alternative option for them.

Facilities and premises were appropriate for the services being delivered. Staff could access emergency mental health support 24 hours a day, 7 days a week for women and birthing people with mental health problems and learning disabilities. Staff were complimentary about the support provided by the trust's specialist midwives; they had support from several specialist midwives for any women or birthing people with complex needs. This included homeless people, asylum seekers, teenage mothers, mental health, substance misuse, feeding support, bereavement, and safeguarding midwives.

Services for teenagers were stretched geographically, however, the midwives attended child in need/child protection meetings, supported antenatal education and worked closely with the family nurse partnership to ensure they had oversight of any challenges.

The service had systems to help care for women and birthing people in need of additional support or specialist intervention. Women and birthing people with mental health conditions or living with a learning disability had their needs met. Staff were aware when women or birthing people needed additional support as the electronic patient records system flagged this requirement.

Managers monitored and took action to minimise missed appointments. Women and birthing people received a reminder text message before their antenatal appointments. Managers ensured women or birthing people who did not attend appointments were contacted. Administration staff monitored when they did not attend appointments. They contacted women and birthing people to offer them another appointment to ensure they were rebooked to attend.

The service relieved pressure on other departments when they could treat patients in a day. The service ensured women and birthing people could attend multiple specialist antenatal clinics and have any scans or tests on the same day where possible, to avoid them having to return on several separate occasions.

There were midwifery and consultant led clinics at the service for women and birthing people to access.

There was an alongside midwifery led unit called Wrekin MLU within the unit, which provided midwifery led care to women and birthing people who were deemed as low risk. Alongside refers to the unit being next to or near the obstetric unit.

The service ran 'Rainbow clinics," which were for women or birthing people who had experienced a pregnancy loss and were planning future pregnancies. It was recognised that women and birthing people who had experienced a pregnancy loss had greater anxiety and required additional support and monitoring. The clinics were run by a consultant obstetrician and specialist bereavement midwives.

Facilities and premises were appropriate for the services being delivered. The Bereavement Suite was located inside the delivery suite, which was not the most appropriate location due to hearing labouring women, birthing people, and babies when they and their family had lost their own baby. However, we did not hear any outside noise while inside the

suite. Families could stay with the woman and their baby for as long as needed, in a self-contained area, which had been furnished. Several considerations had been explored regarding the location of the bereavement suite; however, all mitigations were in place while waiting for it to be relocated to The Royal Shrewsbury Hospital as part of the transformation programme.

Babies were laid in cold cots but could be held for periods by the woman and her family as part of their grieving process. The families were supported by the bereavement midwives who also helped with procedures following a loss to relieve the burden on the family in the initial phase.

Visitation for partners of women and birthing people was in place and staff said they were always considerate of the women and birthing people's needs and preferences whilst in hospital.

The service had systems to help care for women and birthing people in need of additional support or specialist intervention. The electronic systems used both by community midwives and the one used within the maternity unit had the function to flag women or birthing people who required additional support. When a woman was identified as requiring additional support, the service had links with external organisations which they would signpost them to.

The trust's website contained a dedicated maternity section. The maternity pages provided information about antenatal care and services, labour, and postnatal care and support. Antenatal classes were available at weekends and evenings.

The service was keen to ensure they were accessible to all and gave examples of supporting women and birthing people to manage anxieties associated with childbirth or challenges for people with additional needs, such as learning disabilities, hearing, or sight loss. All women and birthing people were afforded individualised care including discussions around what would make their pregnancy and birth more manageable, walkarounds to familiarise with environment, procedures, and staff, needs to be met for interpreting service including British Sign Language. The service used an interpreting service for women and birthing people, which was available virtually or in person. British Sign Language interpreters were accessible when required and they had an ongoing review at the time of the inspection to include access to video interpreters.

Meeting people's individual needs

The service was inclusive and took account of women and birthing people's individual needs and preferences. Staff made reasonable adjustments to help women and birthing people access services. They coordinated care with other services and providers.

Staff made sure women and birthing people living with mental health problems and learning disabilities received the necessary care to meet all their needs. The maternity service had specialist midwives in mental health and learning disabilities to support women and birthing people. Staff supported women and birthing people living with learning disabilities by using 'This is me' documents and patient passports where applicable. Staff ensured any additional needs, which were required when the woman was admitted, were part of their plan of care. All women and birthing people with complex needs had a specialist midwife involved in their care for example, who attended multidisciplinary meetings and ward rounds.

Staff understood and applied the policy on meeting the information and communication needs of women and birthing people with a disability or sensory loss. The service had information leaflets available in languages spoken by the women, birthing people, and local community. Staff could provide women and birthing people with leaflets in an easy read format if required. Staff were aware of the requirements to present information in a variety of ways to meet the

needs of women and birthing people using the service. Staff told us they always tried to accommodate any requirements the women and birthing people had. Staff told us, with some women or birthing people they needed to adapt how they communicated with them to engage them better via the use of social media which had been key to reach some groups of women and birthing people.

For women and birthing people who had sensory impairments, the rooms in the delivery suite could be tailored to meet their needs, for example, alternative lighting was available which would reduce any potential sensory overload for them.

We also observed use of a book available on each ward area, titled 'Spiritual and Religious Needs of Patients', containing a summary of each religion or belief and what people of that belief's preferences were. This included foods, medical interventions and arrangements following bereavement.

Managers made sure staff, women, birthing people, loved ones and carers could get help from interpreters or signers when needed. Staff also had access to a telephone interpreting and translation service to support women and birthing people to fully understand their care and treatment.

Women and birthing people were given a choice of food and drink to meet their cultural and religious preferences. Women and birthing people confirmed they were given enough choice regarding food and drinks. Staff provided women and birthing people with hot and cold drinks. The service had coordinated with the local Maternity Voices Partnership to develop The Personalised Care and Support Plan to provide women and birthing people with a document to record all their birth and health and wellbeing preferences.

The Shrewsbury and Telford Hospital NHS Trust received an independent review of maternity services, which was published in the first and final Ockenden reports. A key area highlighted for improvement was communication with service users to ensure they were empowered to make informed decisions about their care, which they could trust to be respected. From this, the service developed their Birth Preferences Card. The card included definitions and the use of symbols to help non-English-speaking women, birthing people and families. The card was co-produced with Shropshire and Wrekin Maternity Voices Partnership and facilitated ongoing discussions throughout the pregnancy journey. Since this was implemented, the cards had been adapted into large whiteboard versions in delivery rooms where those choices were displayed for the whole care team to see. The trust had been approached by several organisations to adopt the card for their service.

We were told the service had struggled to gain feedback from women and birthing people using paper feedback forms which were given to people while admitted or on discharge. They adapted this to use electronic devices, which were taken round to women and birthing people by volunteers on the unit. They were finding this to be a better approach, however, we were told that the electronic devices were only provided in English. Non-English-speaking women and birthing people could still provide feedback in other ways, including the use of the paper forms translation services and social media.

Additional information was available for women and birthing people on the trust's website. Information could be provided in a range of languages. There were also videos on the website which gave information to women, birthing people, and families on what to expect and who to contact with any questions.

Access and flow

People could mostly access the service when they needed it and received care promptly. Managers monitored waiting times for admission, treatment, and discharge.

Maternity

Managers monitored waiting times and made sure women and birthing people could access services, including emergency services when needed and received treatment within agreed timeframes and national targets. Staff monitored and incident reported when women and birthing people did not attend their antenatal appointments. Staff conducted follow up calls to check the women and birthing people's wellbeing and to reschedule their appointment for them. Women and birthing people were triaged on admission into the service to ensure they received the most appropriate care and treatment in a timely way.

Managers and staff worked to make sure women and birthing people did not stay longer than they needed to. Women and birthing people had several appointments and checks scheduled on the same day to limit the number of antenatal appointments they needed to attend.

The triage unit was staffed appropriately and open 24 hours/7days week. There was a dedicated triage telephone line, staffed by a midwife.

The service carried out audits including wait times and any adverse outcomes, of which there were none. They anticipated any breaches of the 15 minutes to triage wait and sought the support from other areas to avoid this. They had an overview of women and birthing people coming into the service and anticipated their priority status to better plan their bed space. For example, if a woman was likely to be rated as 'red' they would arrange in advance for the woman to go straight to delivery suite without requiring a bed space in triage.

We reviewed triage wait times between October 2022 and September 2023 and found that for 7 months compliance was 90% or above; however, there were 5 months where compliance was between 80% and 89.9%. Data also showed there were records where waiting times could not be calculated due to incorrect data entry. This was a particular theme where data was entered retrospectively which led to the appearance that women and birthing people were seen before they attended.

The data also showed the number of attendances for individual women or birthing people and identified the highest number of attendances by a single woman or birthing person was 30. A further 3 women or birthing people had more than 20 attendances. Twenty-four women or birthing people had between 10 and 20 attendances during their pregnancy. The service found there had been no adverse outcome for any of those women or birthing people, however, they continued to monitor the attendances to identify any learning. At the time of the inspection there were no themes emerging other than raised awareness, for example monitoring of fetal movements.

The cases which breached the target time for triage were reviewed by the service on an individual basis, this was triangulated through review of incident reporting and 'red flags' data. No adverse outcomes or harm had been reported. This was being monitored and the service was working against an action plan to improve performance.

Managers monitored the number of women or birthing people leaving the service before being seen at triage or the day assessment unit. Staff said they would attempt to safeguard a woman who was leaving against medical advice and would try to arrange follow up with the woman where possible.

Managers worked to keep the number of cancelled appointments to a minimum. When women or birthing people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff planned women and birthing people's discharge carefully, particularly for those with complex mental health and social care needs. The service had strong links with external agencies to ensure women and birthing people received

appropriate and timely support following their discharge. Staff told us any woman who had complex needs would have detailed discharge plans created with relevant specialist midwife input. We saw examples where staff had completed detailed plans and involved external agencies to ensure women, birthing people and their babies were safe on discharge.

Managers and staff started planning each woman's discharge as early as possible. On the ward, staff tried to ensure the discharge process ran smoothly for women and birthing people. Consultant led ward rounds were conducted early to enable the service to have an overview of how many discharges were likely that day. This information would then be discussed during the multidisciplinary team meeting each day, including weekends and bank holidays, which we observed during our inspection. This was led by the senior leadership team.

Staff supported women, birthing people, and babies when they were referred or transferred between services. The service's vision and strategy included the roll out of the Continuity of Carer model to ensure women and birthing people received care from the same midwife or midwifery team throughout their pregnancy.

Newborn and infant physical examinations were conducted as early as possible to help with the flow on the wards.

Staff told us there was no dedicated senior obstetrician allocated to the triage unit after 7pm, however, they had excellent access to them, monitored wait times and found no impact on flow. Staff said there had been no long waits, incidents or adverse outcomes for women or birthing people who required obstetric review.

The service recorded the number of times when the demand was too high, and diversions and closures were implemented.

The service moved women or birthing people only when there was a clear medical reason or in their best interest. Staff tried not to move women or birthing people between wards at night, however, if they were ready to move to the postnatal ward, and a labouring woman or birthing person required a room on the labour ward, the needs of the labouring person would come first.

Learning from complaints and concerns

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

Women, birthing people, relatives, and carers knew how to complain or raise concerns. Women, birthing people and their partners were encouraged to provide feedback on their experiences. The service clearly displayed information about how to raise a concern in patient areas.

We saw staff had access to the trust policy for complaints on the intranet and knew about the Patient Advice and Liaison Service, which supports patients with raising concerns. There were posters with this information displayed throughout maternity.

Data provided to us by the service showed there had been 45 complaints between October 2022 and September 2023. Seventeen complaints related to the delivery suite, 9 were for antenatal and 4 for postnatal. Of these 45 there were 4 which were overdue, 1 was still under investigation and 3 were awaiting approval and closure that same week.

Staff understood the policy on complaints and knew how to handle them. Staff told us if any women or birthing people raised a concern or issue whilst at the unit they would apologise, try to find resolution, and escalate to the manager of the unit.

Managers investigated complaints and identified themes. Someone from the leadership team always contacted the members of staff involved to feed back to individuals and help them understand the reason for the complaint.

Staff told us themes were shared at handovers, huddles, staff notice boards, their governance newsletter, and by email.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

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

There had been significant changes in leadership since our last inspection. The maternity service had a clear management structure with defining lines of responsibility and accountability. Maternity sat in the women and children's division which was led by a Divisional Director of Operations, a Director of Midwifery, Divisional Director of Nursing and a Divisional Medical Director**.** The maternity service leadership structure consisted of a director of midwifery, head of midwifery and a deputy head of midwifery (not yet in post) who supported the matrons, consultant midwives, ward managers and deputy ward managers.

The director of midwifery and head of midwifery were highly spoken of by all staff we spoke with. The head of midwifery had her office based on the delivery suite which made her accessible and present. All staff told us the director of midwifery and head of midwifery were both visible and approachable and had given the service some stability and were supportive and effective in their roles. Staff spoke positively about the ward managers and matrons, and said they were also visible, supportive, and approachable.

We reviewed board meeting minutes and saw the director of midwifery represented the service at board level. Staff were also welcome to present at the board to share where they were finding challenges or where they had shown improvement. The leadership team had direct access to the trust board and trust board oversight was clearly documented in the board minutes we reviewed.

During interviews, the senior leadership team members demonstrated an overwhelming enthusiasm to improve the service for the women and birthing people who chose to have their babies at the trust, and for the staff who supported this.

Maternity

Leaders had the skills and abilities to run the service. They understood the service's position at the time of their appointments and worked as an entire maternity team to assess the priorities and manage the issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which continually evolved by consistent monitoring, reviewing, and amending where required to achieve the best outcome.

The senior leadership team acknowledged there was still some way to go but spoke with pride about maternity service improvements and the resilience of staff who were committed and enthusiastic. The team were aware of all aspects of the service's performance and the challenges they faced and were clearly highly motivated to continue their journey of service improvement.

The service leaders had strong links with the maternity and neonatal voices partnership (MNVP). Trust leaders, safety champions and the MNVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The maternity service had a vision and workable plans to turn it into action, developed with the involvement of women, birthing people, and the local community. The maternity service's vision was 'To provide excellence in maternity care for the communities we serve'.

The strategy for the service set out their ambition over a 5-year period between 2022 and 2027, it included improving the quality of care provided and making the service more sustainable. The senior leadership team had a focus on many areas to drive sustainability and improvements in care.

The service engaged well with women, birthing people, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The service worked with neighbouring trusts, other stakeholders, and service users to establish the Local Maternity Neonatal System, in line with national maternity recommendations.

The service plans to transform the maternity service and was working ahead of the plans for this to be completed.

Newsletters were produced for staff to inform of upcoming alerts and changes, and to invite staff to engagement activities.

Leaders continued to work towards implementing all actions from the Ockenden Review of the maternity services and continuous internal review of their maternity services. The trust worked towards achieving all 210 actions from the report. At the time of our inspection the service was ahead of their planned dates for completion and did not deem them fully completed until they had been tested and were embedded.

Maternity

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff experience of the culture was positive since the time of the last inspection. All staff we spoke with, without exception said they felt valued, supported, and engaged with the service. We spoke with a range of staff of all grades and some who were new in post. They said they felt supported in their induction phase and always felt confident and competent for their role.

During this inspection we found all staff, including community staff, now worked on rotation over time, to ensure they all maintained their competencies and they were competent to work on any area. Staff attitudes had changed significantly, and the service appeared to work together for the benefit of women, birthing people and babies across the board and understood each other's challenges.

Staff were aware of the Freedom to Speak Up Guardians in the trust and had started to use them regularly to escalate their concerns.

Staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were proud of what they had achieved since our last visit and felt valued and respected by immediate management.

The service had implemented development programmes for staff where they were able to undertake the competencies that would make them eligible to apply for a senior role. There was no increase in banding during this term, however, it gave them valuable experience to apply for a substantive role following this period. A deputy ward manager could work as a ward manager for example, and they were in the process of developing the head of midwifery pathway to enhance succession planning and provide better retention and stability within the leadership team.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders had implemented a governance structure for the service which was effective and provided assurance.

The trust had made significant improvements to the maternity leadership and governance structures. Service leads were enthusiastic about the new governance structure and said they felt it was more streamlined and provided ward to board assurance and improved oversight since our last inspection.

Staff at all levels were clear about their roles and accountabilities. The service had a more stable leadership structure as all leads were now substantive as opposed to the high levels of senior staff in interim posts at the last inspection.

Staff knew who to contact and said all levels of the leadership team were accessible. Staff told us they had good access to the head of midwifery as their office was ward based and they were able to contact them with ease.

The service had implemented a huge number of improvements since our last inspection including, 24/7 onsite presence of obstetric consultant and improvements to the safety and processes for the induction of labour.

Maternity

The incidents within the service continued to be monitored through the quality, risk and safety governance framework. There was a maternity improvement programme in place, which captured all the improvements identified by the Care Quality Commission, Health Services Safety Investigations Body (HSSIB) reports and the Ockenden Review. The leadership team met regularly as part of their governance framework to review this plan and documented actions made against this.

The trust's quality assurance committee had received a detailed update in respect of maternity quality and safety and highlighted the following key points; there had been" a huge improvement in maternity whilst recognising that there was still a long way to go, triage reviews within 15 minutes had been sustained at over 90%, there was a significantly improved staffing position and training compliance was at target for most staff.

We reviewed a range of minutes from different governance and managerial meetings for the previous three months. All had standard agendas, follow-up actions and covered risk, workforce, performance, relevant dashboards, estates, and external visits.

The trust had reviewed and updated all maternity clinical guidelines. In October 2023, 100% of maternity guidelines were in date with allocated renewal dates. This was consistently monitored, and we saw that the head of midwifery had oversight of all guidelines and impending dates for expiry for follow up.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and had plans to cope with unexpected events. There were systems in place to support improvements.

Senior maternity staff monitored maternity performance through the maternity dashboard, with red, amber, and green colour coding. This enabled staff to identify where the department was performing better and where improvement was needed. When we spoke with staff, they were unfamiliar with the term 'maternity dashboard', however, when we spoke with them further, they told us, and we saw each area displayed a risk and governance board, which detailed relevant performance data from the maternity dashboard so information on the outcomes for women, birthing people and babies was displayed in a clearer format.

Maternity performance measures were reported using the maternity dashboard. Some of the metrics used Statistical Process Control (SPC) which is best practice. SPC is a way of presenting data to understand whether change results in improvement.

There was a systematic programme of clinical and internal audits, which were used to monitor risks and quality to identify where action should be taken. We saw all audits were repeated to identify improvement and share learning.

Leaders monitored a workforce dashboard to monitor metrics such as sickness and turnover metrics, which all managers had access to.

The service had a maternity risk register to identify, record, and mitigate risks and mitigating actions. There was alignment between the risks recorded on the risk register and what staff were concerned about. The risk register recorded the dates when the risk was last reviewed, the risk owner, date opened and the date the risk actions should be implemented by.

At the time of our inspection, there were 21 risks recorded on the risk register ranging from 4 (moderate risk) to 25 (extreme risk).

Service leads told us their lack of radiology capacity was one of their extreme risks on the register as waiting times were impacting on neonatal hip scans. This meant babies requiring neonatal hip scans may not be scanned within the 4-to-6-week national standard. There were mitigating actions in place to reduce the risk of harm.

Staffing had been a concern at the time of the last inspection; however, the service had carried out significant recruitment campaigns and secured recruitment over and above their recommended establishment. Although, due to some long-term sickness and other unavailability of staff for maternity leave for example, there were sometimes gaps in the rotas. Maternity leads always filled any gaps with bank staff, who were always familiar with the service.

Following the independent review and our inspection of the maternity services in 2021, the service established a maternity transformation programme (MTP), which created actions for 'Must do' and 'Should do' from the inspection and the recommendations from the Ockenden reports. At the time of our inspection, the trust had surpassed their target and were working ahead of time for completion of MTP actions.

The trust had implemented the best practice Birmingham Symptom Specific Obstetric Triage System which had enabled them to maintain a trajectory of 90% of all women and birthing people in triage being seen within 15 minutes of arrival.

The national Saving Babies Lives Care Bundle (SBLCB) was introduced in March 2016, with an updated version in March 2019 (version 2). SBLCB sets the standard for the national ambition to reduce the pre-term birth rate (babies born less than 37 weeks' gestation) from 8% to 6%, and to reduce stillbirth, maternal and neonatal morbidity, and serious brain injury by 50% by 2025. The trust carried out a self-assessment of all standards with evidence gathered across monthly audits, system data, reports, newsletters and learning events.

To reduce the risk of women and birthing people having a pre-term baby, a quality improvement project had been identified around steroid administration to women and birthing people. Steroids improve lung maturity for babies and this change aimed to ensure 80% women and birthing people receive steroids in line with national guidance. There was still further work to do to improve compliance with access to steroids.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had improved its processes to act on recommendations and actions from external reviews of incidents and the performance of the maternity service. However, the service leaders recognised improvement was still needed but they were ahead of their planned trajectory for completion.

At the time of our last inspection, the birthing rooms in the Wrekin midwifery led unit did not have dedicated computers. This had been addressed since and the unit was now fully established with electronic systems throughout. This meant that patient information was no longer duplicated or had to be manually written by staff and later transferred onto electronic records. This meant staff had up-to-date information about the women and birthing people they were caring for.

At our last inspection the database used to record the maternity specific training compliance rates was not linked to the corporate training database. This meant staff training requirements and due dates were not visible to staff. The trust had addressed this by implementing a database which gave staff easy access to their training information and some ownership for ensuring they complete it.

Maternity

The service used a programme of audit to collect data and analyse this. The trust used a digital platform to collect and review data to monitor performance and risk. This platform supported the completion of audits.

The service had a specialist digital midwife who worked alongside the trust's digital team. The specialist digital midwife also continued to work clinically so they were aware of any issues which staff faced and endeavoured to continue work to improve the systems staff used.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The maternity service was supported by several external organisations to help embed improvements that the service was required to make in response to the requirements of external reviews of the maternity service.

Senior staff were also engaged in sustainability transformation partnerships (STPs) relevant to the whole service.

Maternity staff were engaged with the Local Maternity Neonatal System. The service had a positive and productive relationship the local MNVP who offered support, challenge and co-production to the service. The service in collaboration with the MNVP had introduced the 'UX' ('User Experience) card system to gather direct, actionable user feedback.

The maternity service worked with the MNVP to involve a range of equality groups to inform the planning for the service. The MNVP meetings discussions included increasing the diversity of the MNVP and to discuss how to improve engagement with harder to reach women and birthing people.

The MNVP in Shropshire and Telford, and Wrekin had been working with the maternity transformation team at the trust to ensure the women, birthing people and families voices were being heard and involved in the ongoing transformation work.

Staff within specialist roles and managers, engaged with staff in different ways to ensure they were up to date with some key information. An example of this was the use of a mobile sepsis education board which was taken to different areas for short updates and learning. Similar items for learning and updates were shared in the '3-minute brief'.

The MNVP chair attended the maternity improvement programme engagement and inclusion workstream meetings and had attended the maternity oversight committee. The MNVP is a forum for service users and representatives to work in partnership with staff to ensure maternity services provide family centred care and continuous improvement. The trust encouraged women and birthing people to provide feedback about their experience by getting involved.

The trust had carried out '15 Steps' in maternity. The 15 Steps toolkit was a method which looked at maternity services from the perspective of those who used them. It explored their first impressions of care, their surroundings and the overall experience across their maternity journey. We saw posters around the unit encouraging women, birthing people, and families to support this.

The MNVP shared feedback with the service, which we saw, and the service leads addressed any issues that were raised to meet the needs of women and birthing people using the service.

Maternity

The service had a patient experience and engagement steering group which oversaw patient experience. This group fed into the trust board to ensure maternal and birth partner voices were heard.

We heard from staff that the engagement from the senior leadership team had improved immensely since the structure had stabilised and really appreciated the ease of access to them for advice and support.

Staff reported that they felt comfortable to approach any of the leadership team and were confident they would be taken seriously. They were also comfortable to suggest ways they could improve experiences for women, birthing people and families and were given the opportunity to implement them where possible.

The service held weekly tours of the unit every Sunday where women, birthing people and families could visit, ask questions, familiarise themselves with the unit and the service and share any ideas they had that could enhance the experience for them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Improvements had been made to incident reviews and reporting incidents correctly. However, we were still not assured that incidents were graded appropriately such as graded tears and shoulder dystocia due to a causation focused review process.

The senior leadership team had improved oversight of the relevant risks within the service to identify mitigations and were working in line with associated action plans to address these.

Senior leaders were supported by several external organisations in both clinical practice and incident management to provide an additional level of scrutiny. They assisted the service to act on the outcomes and actions from serious investigation reviews, recommendations from the HSSIB and the first and final Ockenden reviews in a timely way. For example, staff were now conducting fresh eyes checks every hour for continuous fetal monitoring in line with Saving Babies' Lives Care Bundle. This was in response to learning from previous incidents where cardiotocography's (CTGs) had been incorrectly categorised and staff were not always regularly conducting CTG monitoring.

A new Saving Babies' Lives midwife was now in post who monitored the service's progress to implement the actions required by the Saving Babies' Lives care programme.

The service had several examples of innovative practice from the last 12 months. They had developed, in conjunction with the MNVP, a birth preferences card. We heard positive feedback from women and birthing people about this and the service had been approached by a range of other services with a view to adopt this.

The service had a staff development pathway in place to support staff to gain experience in senior roles if they wished and provided them with the necessary experience, they required to take the next step in their career.

The maternity unit had been nominated for a Baby Lifeline UK MUM (Maternity Unit Marvels) Award 2023, which they were immensely proud of, given the challenges the service had faced to improve over recent years.

Maternity

In line with the Better Births Postnatal Improvement Plan guidance which states women and birthing people should have the opportunity to re-visit their birth experience, the maternity service, supported by the Local Maternity Systems and MNVP, had developed a birth reflections service to support women and birthing people's emotional wellbeing.

The maternity leadership had been significantly strengthened and positive working relationships with neighbouring trusts as well as holding webinars which were shared nationally had been implemented. These focused on good practice and learning.

Leaders and staff were committed to continuous learning, improvement, and innovation. The service's senior leadership team had been in regular contact with a similarly challenged service to share learning and support each other to improve their services for women, birthing people and babies. They shared what actions had been tested and provided better outcomes, as well as ones which had not.

Since the independent review of maternity services, regular learning and improvement meetings had been established. The meetings allowed staff to share and learn from case reviews and engage with improvements in a timely manner.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory Training

The service provided mandatory training in key skills to all staff. However, they did not make sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff.

Information received after the inspection showed the training compliance for all staff within the medical service at this location just met the trust's 90% target. However, the information identified there were challenges with a number of the key elements of the mandatory training, as well as departments or wards also demonstrating challenges with meeting the requirements.

Basic life support classroom module, information governance and data management and fire safety were the top 3 subjects that had the highest numbers of departments or wards which had not met the trust target for compliance.

In addition to the low compliance with basic life support training, information showed there were low levels of staff who had completed immediate life support (ILS), paediatric immediate life support (PILS) and advanced life support (ALS). Information provided by the service identified staff within the acute medical unit (AMU) were expected to have ILS, however, the information did not identify any staff from that area having completed this. We were therefore not assured the service had enough suitably trained staff in resuscitation skills.

Most ward staff received and kept up-to-date with their mandatory training. Information received after the inspection showed all wards were above the trust's target for mandatory training apart from wards 15 and 16 which recorded 84%. All specialist nurse groups which were identified in the information were above the trust's 90% target for their training.

Not all medical staff received and kept up-to-date with their mandatory training. Information received after the inspection showed there were variable compliance amongst the medical workforce of all levels. Compliance ranged between 50% for medical staff within the care of the older person speciality, and 100% for senior medical staff within nephrology and physician's assistants working within respiratory.

Staff told us they completed training on caring for patients with additional needs. Information provided after the inspection showed some staff had completed training on recognising and responding to patients with learning disabilities, autism, and dementia.

No wards or departments had achieved the trust target of 90% for any training in relation to dementia, learning disabilities or autism. The trust had introduced Oliver McGowan training for staff which included training in relation to learning disabilities and autism and became a legal requirement in July 2022. Compliance with this training ranged from

0% amongst medical secretaries for various specialities, physician associates and speciality nurses to 89% amongst speciality nurses in stroke. Further information was submitted during the factual accuracy stage which showed the overall compliance had improved from 59% to 85%. The information provided only showed the overall compliance for the service and did not break down to ward, speciality or role level.

No evidence was provided when requested in relation to mental health training. This was an area where staff had felt additional training was required due to the increase in patients admitted with mental health needs.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. However, the information shared with us after inspection identified a large number of wards and departments which were below the trust target for compliance with training, we were therefore not assured the process in place was effective. Staff told us they were given the opportunity to complete their mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff were up to date with training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. Information showed the overall compliance for the medicine service met the trust target for most safeguarding training modules including preventing radicalisation (level 1 and 3), safeguarding adults (levels 1, 2 and 3) and safeguarding children (levels 1 and 2). However, safeguarding level 3 for children was recorded as 50% compliant overall for those who were required to complete this.

The information showed no medical staff working in the acute medicine speciality at this location had completed the training. The information only gave percentages of compliance therefore, we were not able to identify how many staff members this equated to.

Although the trust targets were met for the other safeguarding training topics, the information did identify there were some departments which were well below the trust target. For example, wards 6, 15 and 16 were below the target for radicalisation level 1 training, medical staff within the care of the older person speciality were well below the trust target for all modules they were required to complete (radicalisation level 3, safeguarding adults levels 1 to 3 and safeguarding children level 1 and 2).

Despite the concerns with some of the training for staff, most staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to discuss examples of where they had raised concerns to other agencies or the trust’s safeguarding team.

Children under 16 were permitted to attend the medical wards a long as they were accompanied by an adult, although visiting for children under 6 was generally discussed prior to them visiting to ensure it was appropriate. Staff followed safe procedures for children visiting the wards.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were mostly visibly clean and had suitable furnishings which were clean and well-maintained. However, there were some areas we visited which appeared cluttered and this could impact on the cleaning of the department.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Information provided after the inspection identified all wards were above 90% in relation to their cleanliness audits, which was in line with the trust target.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). All wards we visited were well stocked with PPE for staff and where applicable, visitors to use. Wards which had a high number of COVID-19 patients had reintroduced mask wearing for all who entered the ward. Staff adhered to the World Health Organisations (WHO) 5 moments for hand hygiene and were observed to mostly be ‘bare below the elbow’ to enable effective handwashing. Staff wore PPE correctly and disposed of this in between patients. We observed staff using hand gel or washing their hands appropriately in between patients.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, we found items of equipment which had not been labelled but appeared to have been cleaned after use.

Staff did not always complete infection, prevention and control (IPC) risk assessments for patients on admission. From the notes we reviewed, 65% of those we reviewed had full IPC risk assessments completed. Other patients had partial risk assessments completed which only recorded COVID-19 screening compliance.

Information received after the inspection showed between 1 April and 30 September 2023, there had been 0 MRSA bacteraemia’s, 4 MSSA (Meticillin sensitive Staphylococcus aureus) bacteraemia’s, 6 Escherichia coli bacteraemia’s and 6 Clostridioides difficile (C. difficile) infections within the medical service at this location. All infections were taken seriously, and reviews took place to ensure any opportunities for learning were implemented. Senior members of staff acknowledged this site was challenged in relation to IPC measures (for example, there were lower numbers of single patient rooms for isolation purposes at this location).

During our inspection we observed staff on Ward 10 using an isolation pod for a patient who had tested positive for COVID-19. This enabled staff to provide safe care and treatment to all patients without the risk of exposing others to the risk of infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients we spoke with told us staff responded quickly when they called.

The design of the environment mostly followed national guidance. It was noted that some wards were restricted for space and staff raised concerns over the limited space in some of the bays, especially if additional equipment such as IPC pods, were required to be provided. However, we did not identify any risks to patients and staff did not raise concerns over not being able to access patients in an emergency. All wards had controlled access to maintain a safe

environment for patients. Ward 17 had undergone a refurbishment which was in line with national guidance. During the previous inspection, many areas were identified to be accessible to patients which was of concern and considered a risk. We did not observe any concerns with patients having access to restricted areas during this inspection. However, the service did not have suitable facilities to meet the needs of patients' families. There were not always spaces available for staff to hold difficult conversations with patients and their families.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment had been consistently checked during October 2023 (up to and including the dates of our inspection). Trolleys checked as part of our inspection were found to have equipment which was in date for services and electrical safety tests, and all consumable products were found to be in date.

We reviewed 8 items of equipment and found they were in date for their services and electrical testing. We also reviewed a selection of clinical consumable items including but not limited to cannulas, dressings, airways, suction tubing, syringes, and blood sample bottles. We found 10 blood sampling bottles which were out of date on AMU. We handed these to the nurse in charge who ensured all other items were in date and safe to use.

The service had enough suitable equipment to help them to safely care for patients. All staff we spoke with told us they had adequate amounts of equipment to enable them to complete their jobs.

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with the trust policy.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Most staff identified when patients were at risk of deterioration, however we were not assured there was always quick action taken.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital used the National Early Warning Score 2 (NEWS2) for the detection and response of deteriorating patients. We reviewed 23 records for patients admitted within the medical wards or under the care of medical specialities and found observations were completed according to the frequency required for the patient. Staff inputted the observations into the electronic system, and this calculated the NEWS2. When patients scored outside of the acceptable parameters, an alert was placed on the system which staff accessing that patient's record would see. Each ward also had a board (patient status at a glance- PSAG) which contained the NEWS2 to ensure all staff had an oversight of any patients who were potentially at risk of deterioration and prompted action when required. We identified patients who had a higher NEWS2 and followed up on the care and treatment they required. We found patients had been escalated and reviewed appropriately. However, information received after the inspection showed the wards were not always ensuring patients received timely follow up.

The service undertook monthly deteriorating patient audits which assessed the NEWS2 data and response from staff, this showed between July and September 2023, there continued to be challenges in relation to ensuring patients who showed signs of deterioration were having timely follow up and repeated observations taken. Wards 15 and 17 continued to be identified as wards where patients were not always having the appropriate follow up when identified as deteriorating.

Deterioration stickers remained in use within the service. Where patients were escalated for further medical review, the stickers were used to highlight what assessment and action had taken place. We observed stickers in 3 records we reviewed, 1 patient had numerous stickers due to their unstable clinical condition. We found most stickers were completed well and were detailed. However, we found 1 sticker which had not been completed. There was evidence within the notes that the patient had been reviewed and actions taken.

Training information showed staff compliance with life support training was below the trust target in a large number of areas within the service. Information provided after the inspection also highlighted areas which were expected to complete higher levels of resuscitation training. However, the information did not demonstrate a high number of staff completing this training. Areas such as the acute medical unit (AMU) which were expected to complete the immediate life support training (ILS) had no evidence of staff completing this training. Areas which had staff recorded as completing either ILS or advanced life support (ALS) were low in numbers. The information, however, did not identify how many staff were expected to have completed the training. This information did not assure us that staff would be competent and quick to act if a patient deteriorated within the clinical areas.

Staff completed some risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. These risk assessments included but were not limited to a patient's risk of skin damage, malnutrition risks, manual handling and falls risk. Risk assessments were paper based booklets which staff held in patient files.

We reviewed 23 documents and found there had been a general improvement in the completion of these documents from the previous inspection. Where risks were identified, we were able to identify what actions staff had taken to mitigate or eliminate the risk for patients. Bed rails risk assessments were previously raised as a concern with staff inappropriately using bed rails for patients who were deemed not safe. However, we found staff completed these risk assessments accurately and no evidence of inappropriate use of bed rails was observed during this inspection.

Staff knew about specific risk issues. However, staff did not always manage the risks appropriately. We reviewed 22 venous thromboembolism (VTE) risk assessments and observed failures to complete the risk assessment in line with trust policy within all of those records. There were no VTE risk assessments completed on admission for 8 patients with a further 4 records appearing to show a delay in them being completed (but completed within 24 hours of admission). All records reviewed failed to have a VTE reassessment completed 24 hours after admission, which was required under the trust policy. One record did identify 2 reassessments; however, the first of these were over 24 hours after admission.

Despite the VTE risk assessments not being completed in line with trust policy, we found all patients had prophylaxis prescribed or anti-embolism stockings in place as a preventative measure. We were concerned that this was a risk in itself due to not all patients being suitable for these measures which would only be identified through thorough assessment.

Staff received sepsis awareness training and completed sepsis screening for patients when concerns were raised. During our inspection, we observed 2 patients who were identified as potentially septic. We also reviewed some notes for a patient who had recently been escalated for deterioration. We found sepsis screening was not always completed in line with recommended guidance. Prompt sepsis screening was essential as there is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. Where we observed a delay in sepsis screening, staff told us this was incident reported and the patient had since been screened and action taken.

The service monitored their own performance against the sepsis bundle. Sepsis performance was completed as part of the deteriorating patient audits. Performance appeared inconsistent between July and September 2023 with wards scoring between 0% and 100% for recognising and acting on medium risk patients, recognising and acting on high risk patients and administration of intravenous antibiotics within 60 minutes of identification of red flag sepsis.

The service had an action plan in place to improve the identification and management of a deteriorating patient including those at risk of developing sepsis.

Diabetic patients were effectively assessed and had action taken to monitor their blood glucose levels. This was identified as an improvement since the last inspection. Where patients were identified to have either high or low blood sugars, appropriate action was taken to manage these patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff were aware of this process and would access them if support was required.

Staff told us psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide would be completed. However, we did not observe any patients requiring these assessments during our inspection.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Safety huddles were also conducted after handover where specific safety issues were identified, and actions assigned to staff to ensure the safety of the ward.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There was a reliance on bank and agency staff to maintain safe staffing levels.

The service did not have enough nursing and support staff to keep patients safe. During our inspection we found most wards were staffed according to their planned numbers. However, information received after the inspection identified there were significant vacancy rates for nurses and other clinical staff. The information highlighted the service were reliant on agency and bank staff to ensure staffing to patient ratios were maintained to keep patients safe.

The service had vacancy rates within nurse staffing and ‘other clinical’ staff that solely worked at this location. The information showed there was a vacancy rate of 23.10 whole time equivalents (WTE) for nursing staff at this location and 10.7 WTE vacancy for other clinical staff. This information did not show which wards were mostly impacted by this vacancy rate. The information also showed there were vacancy rates within nursing staff and other clinical staff who worked across both sites. There was a 14.9 WTE vacancy rate for nursing staff and 1.23 WTE vacancy for other clinical staff who worked across both sites. The information did not indicate whether the vacancies were reducing or improving. Since the inspection, the trust has continued to recruit into their vacant positions. Further information provided showed a reduced vacancy rate of 7.14 WTE for nursing posts. This was as a result of internation nurses having commenced their posts. By the end of March 2024, the medical services were over-recruited for band 5 nurses.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Where staffing levels were low and patient acuity was high, managers would escalate their concerns to the site team who would try to re-deploy staff to make the area safe.

The number of nurses and healthcare assistants matched the planned numbers. Wards we visited mostly had their actual staffing matching the planned staffing. The exception to this were Ward 15 which had 1 less registered nurse on the early and late shift.

The service had an average turnover rate of 4.8% for the ward nurses between October 2022 and September 2023. Further information provided during the factual accuracy stage identified the turnover rate had reduced to 2.9% between October 2023 and March 2024. Wards 15 and 16 had the highest turnover rate amongst the wards of 11.5%. Information provided after the inspection also showed there had been a higher-than-average turnover rate amongst the stroke and lung specialist nurses recording 9.9% and 50% respectively. Within some of these teams, it was acknowledged that they would only be small teams giving a larger percentage of turnover. However, the turnover impacted on the capacity of the remaining individuals whilst recruiting for new members of staff. Further information provided during the factual accuracy stage identified the turnover rates within these specialist teams had now stabilised and no further staff had left these teams.

The whole medicine core service had an average sickness rate of 6.1% between April and September 2023. Information showed there were areas within the location inspected which had a higher-than-average sickness rate, this included Ward 6 with an average sickness rate of 7%, Ward 7 with an average sickness rate of 14.5% and Ward 17 with an average sickness rate of 8%. The information also identified some of the specialist nurse groups within this location with a higher-than-average sickness rate. The specialist nurses for stroke recorded an average sickness rate of 6.54% and the lung specialist nurses recorded an average sickness rate of 7.9%. The leadership team were aware of the sickness rates, however they were confident that they were now on a reducing rate across all specialities.

Managers did not limit their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Information received after the inspection showed many areas operated on a lower substantive staff level and relied on agency and bank staff to ensure safe levels of staffing. The level of substantive staff recorded in September 2023 ranged between 25% on the medical day unit to 92% on renal dialysis. Wards 15 and 16 had the lowest recorded substantive staff recorded of all wards, recorded at an average of 61%. In September 2023, Wards 15 and 16 had the highest agency use for the month, which were recorded at 20%, as well as Ward 11 which recorded 15%. Bank staff requirements were also high for these wards. Ward 15 and 16 recorded 19%, Ward 11 recorded 16%) however, Ward 9 recorded the highest bank staff levels as 25%. However, it was noted the overall fill rates were recorded as 91% which meant safe staffing levels were maintained.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service mostly had enough medical staff to keep patients safe. Medical staff told us they were adequately staffed with no major gaps in most of the medical specialities, with the exception being within stroke services. To ensure there were no gaps with the service they provided, medical staff from a different NHS trust provided support to the service.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The medical staff mostly matched the planned number. Information received after the inspection identified there had been some gaps on the rota however staff did not identify this as a concern, with most gaps reportedly down to short term sickness.

There was a small vacancy for consultants at this location. Information provided showed there was a gap of 1.91 WTE for consultants who worked at this location. They had an additional 2.61 WTE vacancy for consultants who worked across

both sites. The information showed there were no vacancies for medical staff on all other levels either at this location or those who worked across both sites. The information provided at the time did not identify which speciality had the vacancy and did not identify if this were improving or reducing. However, information provided during factual accuracy identified there were vacancies within cardiology and care of the elderly. Action was being taken to address these vacancies however, it was reported this was creating significant pressure within the cardiology team.

Information received after this inspection showed there had been no medical staff leave the trust in the last 6 months.

Sickness rates for medical staff were mostly low at this location. The only exception to this was for medical staff working in the care of the older person speciality who recorded an average sickness rate of 9.26% between April and September 2023. These were higher than the overall sickness rate of 6.14% for the complete medical core service.

The service had stable rates of bank and locum staff. Information provided after the inspection showed there was a steady requirement for bank and agency (locum) doctors for this location. The most recent information for September 2023 showed there had been a slight decrease in the number of hours which required bank and locum cover, from the previous months. There had been a requirement for bank and locum doctors for most grades of doctors with the exception being specialist and speciality doctors. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. The service ensured rotas were staffed to provide a high standard of care for all patients regardless of the time or day of the week. Arrangements for handovers and shift changes ensured that patients were protected from avoidable harm.

Records

Staff did not always complete detailed and individualised records of patients’ care and treatment. However, records were up-to-date, stored securely and easily available to all staff providing care.

Patient notes were not always comprehensive. Patient records were mostly paper based, with the exception of the observation records, pain record and venous thromboembolism (VTE) risk assessment. We reviewed 23 sets of nursing and medical records and found most of the medical records were completed with enough detail to ensure accurate patient care and treatment was conducted. VTE risk assessments were identified as a specific concern when reviewing documents, however this has been reported on under assessing and responding to risk due to the safety concerns associated with this. The nursing records were previously identified to be generic and lacked individualisation to the patient they referred to. We found the service were still using the same nursing care plans however staff told us an additional box had been placed within each record where individualised goals and objectives could be documented. We did not observe any of the 23 sets of nursing records with any information recorded in these boxes. We also found some care plans which had not been given specific consideration for the patient this referred to, for example specific issues relating to patients of a childbearing age. Overall though, we found staff had mostly completed them accurately and comprehensively, which was an improvement since the previous inspection.

We observed some quality issues with some additional documents which were in use during this inspection. Some documents were identified as photocopies of a photocopy and key information on the document was now missing or illegible.

We found staff mostly completed entries in the patient records in a legible manner and signed, timed, and dated their entries. A large proportion of staff had stamps with their professional details within them which clearly identified accountability for the entries.

When patients transferred to a new team, there were no delays in staff accessing their records. All staff could access them easily. Staff did not raise concerns about records not being available when patients were admitted or transferred from a different department.

Records were stored securely. All wards stored the records in trolleys which were locked. Staff were cautious when accessing these trolleys to ensure the pin code to open them was not observed by unauthorised staff.

Medicines

The service mostly used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The pharmacy team ensured there was a patient centred approach to medicine optimisation. Pharmacy advice summary notes were observed attached to medicine charts to alert and provide advice on safe prescribing. The Education and Training Lead Pharmacist undertook staff training on medicine management systems, safe prescribing, and the use of the electronic prescribing systems. There was a system for recording the site of application or removal of transdermal medicine patches. This is important to check that the patch is still in place or to prevent the application of other patches in error. Also, to communicate information about patches when a person is transferred between wards or other healthcare settings. Allergy statuses of patients were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely. Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The antimicrobial stewardship pharmacist undertook reviews and snap-shot audits which highlighted any areas for improvement. VTE protocols were in place.

Staff reviewed each patient’s medicines regularly and provided advice to patients and carers about their medicines. Members of the pharmacy team regularly reviewed patients’ medicines throughout their admission and prior to discharge. This involved counselling and discussions with patients wherever possible. We observed a pharmacist on the acute medical unit counselling a patient about their prescribed medicines and checking they had enough medicine supplies on their discharge.

Staff did not always complete medicines records accurately and keep them up-to-date. Documentation of medicines administration including routes of administration and specific times of administration were completed on the medicine records reviewed. Staff understood that some medicines had to be given at specific times called ‘time critical medicines’ such as in Parkinson’s disease, and used reminder alarms on mobile phones to ensure these medicines were not missed. However, the tick box for ‘VTE risk assessment’ on medicine charts had not been ticked on any of the charts reviewed. It was therefore not clear if the necessary VTE risk assessment had been undertaken prior to prescribing any treatment.

Staff mostly stored and managed all medicines and prescribing documents safely. Medicines were stored safely and securely. Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use. Controlled drugs (CDs are medicines requiring more control due to their potential for abuse) were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff twice a day. Checks of CDs showed they were mostly within date and stock balances were accurate. However, we found out of date CDs on Ward 15 which had been checked for 11 months. We raised this immediately with the ward manager and this was rectified.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicine optimisation was undertaken by members of the pharmacy team. Any discrepancies were immediately identified and highlighted to the relevant team.

Staff learned from safety alerts and incidents to improve practice. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust. Staff explained and gave examples of learning from medicine issues. Staff were notified and kept updated on any medicine issues through twice daily huddles and the 'one minute brief' information on the trust intranet.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Decision making processes including a mental capacity assessment were in place for staff to follow if a medicine was administered to manage agitation or aggression (rapid tranquilisation). A rapid tranquilisation (RT) policy was available which staff were aware of. RT was reported as an incident which was then checked to give assurance that it was used appropriately and safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

There were 2,352 incidents reported between October 2022 and September 2023. The majority of these incidents were graded no harm (1,435) or low harm (878). There had been 7 incidents graded serious harm and 5 deaths. Most of these incidents had been recorded as incidents around implementation of care and ongoing monitoring and review.

The service had reported no never events on any wards. Not all staff were able to recall when the last never event was, however, staff told us they would usually be informed of any relevant never events which were applicable to their practice.

Staff reported serious incidents clearly and in line with trust policy. There were 28 serious incidents reported between September 2022 and September 2023 under the trust medical speciality (not location specific). This accounted for 25% of all of the trust's serious incidents that were reported during this time. Of these 54% were related to slips, trips and falls.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. We reviewed a selection of serious incidents and identified duty of candour had been appropriately undertaken in each of them. Staff were also aware of the requirement to be open and transparent when things went wrong and would offer an apology to patients.

Staff mostly received feedback from investigation of incidents, both internal and external to the service. Most staff we spoke with confirmed they received feedback from incidents they raised.

Staff met to discuss the feedback and look at improvements to patient care. Learning from incidents was a standing agenda item on ward meetings. This gave staff the opportunity to discuss significant incidents where learning had been identified. Staff were also made aware of important issues raised from incidents during safety huddles.

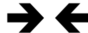
There was evidence that changes had been made as a result of feedback. Staff were able to discuss examples of changes made locally as a result of learning from incidents.

Medical care (including older people's care)

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed a selection of root cause analysis investigation reports in relation to this core service. The investigations appeared thorough, with learning identified and an action plan produced to support improvements.

Managers debriefed and supported staff after any serious incident. During our inspection, we were aware of a debrief which was occurring as a result of a significant incident which occurred. This was attended by staff of all levels from the medical service.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff endeavoured to deliver high quality care and treatment in line with in date policies, procedures and guidelines which were based on best practice and national guidance and policies where available. Staff mostly assessed patients' needs and planned and delivered care in line with National Institute for Health and Care Excellence (NICE) and the relevant royal societies.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients. Details of patients sectioned under the Mental Health Act were also shared during safety huddles, enabling staff to identify if any further measures were required to keep patients safe. In addition to patients who were under a section, patients who were being deprived of their liberties were also identified and any additional measures or follow up were discussed during the safety huddle.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed staff ensuring they asked patients what they would like for their meals and assisting patients who required help to ensure they were adequately nourished. Food charts were updated following each meal. Meals were available to patients to meet all religious and cultural needs and met the needs of those with allergies and intolerances. Patients were positive about the choices of food available for them.

Staff did not always complete patients' fluid charts fully and accurately. The service used a food chart which also recorded fluids. We found these were generally completed well, however we noted there were patients who appeared to have little fluid recorded which caused a concern over how staff were meeting the hydration needs of patients.

The service also used specific fluid balance charts for patients where concerns were identified. We reviewed 6 fluid balance charts and found 50% of these were completed accurately. In the remaining 50% we found staff were not accurately recording the output for patients, leading to inaccurate balances. This meant it was difficult to assess whether the patient was in a positive or negative fluid balance, which could impact their medical condition.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Where concerns were identified about the patient's nutritional status, staff escalated them appropriately for further assessment and support. Where concerns about a patient's nutritional status or support was required to help patients with their meals, these were highlighted on the patient status at a glance (PSAG) board.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Where patients were identified as requiring specialist support, we observed documented evidence in the patient records of reviews.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients for pain during routine observation times using a numerical scoring tool. Staff had access to alternative pain assessment tools for patients who were unable to verbally communicate. We observed staff using these tools to accurately assess a patient's pain.

Staff prescribed, administered, and recorded pain relief accurately. Where patients reported experiencing pain, they received pain relief soon after requesting it. Patients told us they were regularly asked during medication rounds whether they required additional pain relief and administered this promptly if required.

Staff had access to the pain management team for advice.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The service had continued to submit data for the Sentinel Stroke National Audit Programme (SSNAP) on a quarterly basis. Results from April to June 2023 showed the service at The Princess Royal Hospital was graded C overall (this was using a scale of A to E where A is considered the best). However, it was noted that the service continued to be graded as an E for domain 2, the overall team centred rating score for key stroke unit indicator which was much worse than other hospitals. This had been graded as an E for the previous quarter as well. Other audits which were conducted against a national standard included Hospital Acquired Pneumonia and the use of antibiotics (against NICE Guidance 139) and treatment of Community Acquired Pneumonia in line with the British Thoracic Society bundle (national CQUIN).

Outcomes for patients were mixed and did not always meet national standards. The results of the Community Acquired Pneumonia audit had indicated the service was only 7% compliant against a CQUIN threshold of 45 to 70%. Information provided during the factual accuracy stage showed the service had undertaken another audit and results

had identified a small increase in compliance against the CQUIN of 12%. However, the SSNAP outcomes had shown some improvements within some of the domains including the occupational therapist and speech and language indicators. This meant an improvement in the provision of the service for patients who attended following a stroke, which ultimately leads to better patient outcomes. The national audit of dementia care in general hospitals (5 August 2023) showed there were some key metrics which was similar to the national performance or had exceeded national performance. However, there were also some areas which the service had score below the national performance, including pain tool and initiation of discharge plan in the first 24 hours.

Where audits were conducted, action plans were completed to identify work streams to drive further improvements in the services and ultimately patient outcomes.

Information from insight showed the medical service was better than other trusts for emergency readmissions for acute myocardial infarction and pneumonia from January to December 2022. However, there were areas where the data indicated a decrease in performance for this service. This included acute cerebrovascular disease, chronic obstructive pulmonary disease and bronchiectasis and septicaemia. These indicators although had shown a decline in performance, they were currently identified as about the same as other hospitals. The information was for the medicine core service and was not broken down to site level data.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment. Information shared after the inspection showed an example of an audit which followed up a previous audit recommendation to identify if there were improvements to patient care. This was just 1 example of where the ongoing audit cycle was used positively to ensure recommendations had been implemented and improvements to care evidenced.

Managers shared and made sure staff understood information from the audits. Audit information relevant to staff areas was disseminated and improvements to care implemented where appropriate.

Improvement was checked and monitored. The service had an acute ward dashboard which enabled managers to keep an oversight of key performance indicators. There were 59 metrics on this which included (but were not limited to) falls (total numbers and those with harm), pressure ulcers at different stages, dementia screening, controlled drug storage, incidents of moderate, severe and death and sepsis screening. This data was regularly reviewed at speciality governance meetings.

The endoscopy unit had JAG (Joint Advisory Group on gastrointestinal endoscopy) accreditation at the time of our inspection.

Competent staff

The service made sure staff were competent for their roles. However, not all staff received their appraisals of their work performance.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Where applicable, managers made sure staff received additional training for their role and completed competency packages.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers told us they supported nursing staff to develop through regular, constructive clinical supervision of their work. However, information received after the inspection showed there were variable compliance rates across the ward staff for appraisals. The highest compliance rate was 100% compliant (recorded by both wards 10 and 11) compared to the lowest of 61.8% (recorded by Ward 6).

Managers mostly supported medical staff to develop through regular, constructive clinical supervision of their work. Most of the medical specialities recorded 100% compliance with their appraisals for all levels of medical staff. The only exceptions to this were medical staff from the care of the older person speciality which recorded 75% and medical staff from nephrology which recorded 50%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Key issues or messages were also delivered at safety huddles.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The clinical educators supported the learning and development needs of staff. Specialist nursing staff were also identified as key individuals in developing staff's learning and development.

Managers identified poor staff performance promptly and supported staff to improve. Managers would engage with the human resources (HR) department for further advice and support for managing staff performance if required.

Multidisciplinary working

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

The multidisciplinary team consisted of doctors, nurses, healthcare assistants, physiotherapists, pharmacists, dietitians, and specialist nurses (including stroke, learning disability, respiratory). All members of the team worked well together to ensure the best outcome for the patient. All staff spoke positively about the support they received from the wider multidisciplinary team (MDT). Wards also had discharge coordinators who were identified as key individuals in the successful discharge of patients, especially those who were identified as complex discharges.

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. Patients had their care pathway reviewed by relevant consultants. We observed 2 MDT meetings during our inspection. These were well attended and included external professionals in 1 of the meetings. Both meetings were observed to have good engagement however it was noted that within 1 meeting, this was run differently depending on which physician was leading the meeting. There was more collaboration noted in the second half of 1 of the MDT meetings, however both were observed to ensure plans were in place for patients for safe and effective discharges.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were complimentary about the mental health liaison team and their responsiveness.

Seven-day services

Not all services were available 7 days a week.

Consultants led daily ward rounds did not occur for all medical patients 7 days a week. Patients were reviewed by consultants depending on the care pathway they were under. There were consultant led ward rounds for patients who were due to be discharged as well as a consultant available on weekends for acutely unwell patients.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. The endoscopy unit also provided an on-call service for patients admitted as an emergency for gastrointestinal bleeds.

Medicines advice and supply were available 7 days a week. An on-call pharmacist was available outside of core working hours.

Not all therapy services were available 7 days a week. Speech and language therapists were not available during the weekends. Staff from the stroke wards told us they had enhanced the skills of some of the senior nurses within the wards to enable swallowing assessments to be conducted.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Information was available to patients and their relatives which was aimed at promoting healthy lifestyles, as well as educating patients on certain health issues. We observed a lot of health promotion literature around the wards which provided patients with information to enable them to live healthier lives.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff were also able to signpost patients and their relatives to other services for further information and support if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff mostly supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, training around the Mental Capacity Act and Deprivation of Liberty Safeguards was below the trust target.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. All staff were aware of gaining consent from patients prior to completing any treatment or procedure. This also involved implied consent from patients when undertaking activities such as monitoring a patient’s blood pressure. Where more formal consent had been required to undertake clinical procedures, these were completed in accordance with policy and legislation. When patients were assessed as lacking capacity to consent for their procedures, staff knew what process to follow to ensure consent had been obtained in relation to the patient’s best interest.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients’ records. Most of the patients we spoke with told us they had enough information about their conditions to provide informed consent. However, there were some patients who felt they were unaware of what was happening to them, and this could impact their decision making.

Medical care (including older people's care)

Staff did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information provided after the inspection showed some challenges with completing the training. All wards reported compliance levels with mental capacity and deprivation of liberty safeguards training below the trust target of 90%. Compliance for the wards ranged between 65.6% and 88.6%. There were also some challenges with medical staff within some specialities. Medical staff and senior medical staff within cardiology reported lower than the trust target for this training at 66.7% and 83.3% respectively. Senior medical staff within respiratory were also below the trust target with a compliance level of 80%. No additional information on how the service intended to ensure all staff completed this training was provided.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Despite training compliance being below the trust target, staff spoke confidently about identifying patients for whom there were concerns over their capacity to make decisions over their care, and treatment and actions they needed to take to assess this. Staff knew who they could approach for support if they had any queries over patients under their care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Not all areas admitted young people, however in those areas which did, staff understood Gillick Competence and Fraser Guidelines and would support children who wished to make decisions about their treatment. At the time of our inspection, there were no under 18s being cared for on the wards which would accept young people. On AMU, as part of their morning huddle, they would address whether there were any young people admitted.

Managers monitored how well the service followed the Mental Capacity Act and the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Patients who were being deprived of their liberty all had the correct paperwork in place and there was ongoing monitoring of their situation to ensure this was completed in line with legislation.

Is the service caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed care being provided to patients in a dignified manner. When receiving personal care, staff ensured curtains were closed to protect patients’ privacy and dignity. All patients we spoke with were complimentary about the staff who were delivering care and treatment. Most patients felt staff were compassionate towards them and this was reflected in the service’s own inpatient survey which showed most wards scored 100% for the compassionate care question.

The exceptions to this were Ward 11 (which scored 87.5%) and Ward 9 (which scored 50%). However, patients were observant of the busy and 'fast pace' staff were working in and felt this sometimes impacted the time staff took to provide care and treatment.

Patients said most staff treated them well and with kindness. Patients or their relatives mostly told us how kind staff were in relation to how they were cared for. There were a couple of patients who had experienced slightly negative interactions with some staff and had wanted to discuss this with the managers of the wards they were in. However, the majority of patients had told us how kind staff had been to them.

Staff followed policy to keep patient care and treatment confidential. There were no concerns in relation to breaching confidential information. Staff were aware of their surroundings when discussing private patient information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed examples of respectful and non-judgemental care and treatment for patients who were admitted with additional needs other than their physical health needs. Despite the challenges they posed, staff were respectful and caring at all times. Staff were complimented on their patience and compassion in how they cared for all patients.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff were able to discuss examples of care when they had respected the specific needs of a patient. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst admitted.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. In addition to ward staff providing emotional support to patients and their families, we also observed compassionate care being delivered by specialist nurses and other members of the multidisciplinary team. Faith leaders were also available to provide support to patients and their families if this was required.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff ensured any patient who became distressed had their dignity maintained at all times. This also applied to any relatives who arrived to see patients. Staff acknowledged the information they shared with relatives was not always positive and they ensured they were in a private area if they needed to discuss some delicate information.

Chaplain support was available 24 hours a day 7 days per week. The chaplaincy team were from a range of faiths and beliefs. The chapel was open 24 hours a day, every week. Chaplaincy services were available to patients at their bedside for those who were unable to attend chapel.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff demonstrated empathy when having difficult conversations. Patients told us staff were supportive and empathetic when having difficult conversations with them.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff supported patients to make advanced and informed decisions about their care. Most patients told us they felt they were well informed of their care and treatment, and that staff took their time to discuss their care with them. However, there were some patients who did not feel as though they were completely up to date with their care, however acknowledged staff had taken time to go through some concerns with them. Patients recognised staff appeared very busy and this could impact on the time spent with patients to explain things clearly to them.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. When staff spoke with patients, they tailored the conversation to meet their needs. We observed staff tailoring their conversations with patients to ensure it was on the correct level. Information from the services internal inpatient survey between April 2022 and May 2023 showed patients were generally happy with how staff spoke with them, with most wards scoring 100% for this measure. The only exception had been Ward 7 who scored 75%.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff provided information about the Friends and Family Test (FFT) to patients to encourage them to provide their feedback. In addition to this, the wards completed inpatient surveys which they encouraged patients to complete.

Patients gave positive feedback about the service. The main source of feedback was through the FFT. Information received after the inspection showed most wards received positive feedback from patients following the care and treatment provided in this service. The information showed between 88 and 100% of the patients who received care and treatment at this service between April and September 2023 would recommend the service to their friends and family. Wards 15 and 16 both received a consistent 100% positive response between this time. It was however noted that some wards had a very low response rate, however the information showed there had been an increase in the latter part of this period.

In addition to the FFT, the service collected their own inpatient feedback. We received the results of 2 surveys which the service had completed, 1 ran between April 2022 and May 2023 and consisted of 23 questions. The other survey ran during September 2023 and focused on 5 areas of care and treatment. In the larger survey which ran for over a year, the results of this were diverse however provided some rich feedback about the quality of the care and treatment being delivered. One area which provided very diverse responses was around patients being given the opportunity to discuss their worries and fears, the feedback ranged between 25% and 100% of patients feeling they had the opportunity to do this. An area which provided mostly positive responses was the question which asked patients if they had confidence in the nurses looking after them. Between 80% and 100% of patients responded to indicate they did have confidence in the nursing staff. The information from the survey indicated some areas for wards to work on improving the patient experience, however the service did not share any further details on what they had done with valuable information.

The second survey had been very focused on key aspects of a patient’s journey including the cleanliness, patient moves, opportunities for remaining independent with care and treatment and the variety of food being offered. The results of this survey identified there was some significant concerns in relation to patient moves and the rationale for these moves. The information from the survey again indicated some areas for wards to work on, however the service did not share any further details on what they had done with this information.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement

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

Service planning and delivery to meet the needs of the local people.

The service mostly planned care in a way that met the needs of local people and the communities served and worked with others in the wider system and local organisations to plan care. However, the service did not always provide care in a way that met the needs of the patients.

Managers planned and organised services, so they met the changing needs of the local population. The service had systems to help care for patients in need of additional support or specialist intervention. The hyper acute stroke unit (HASU) was centralised at this location and the service was available 24 hours a day. Protected beds were available to ensure patients were able to receive prompt thrombolysis. Additional support was also provided by another NHS trust if thrombectomy had been required. Transport by air ambulance was provided for these patients to ensure timeliness of their treatment.

The service continued to try and improve the experience older patients had when coming to the hospital. Staff commented on the positive in reach from the frailty team to try and avoid unnecessary admission where possible, but also to reduce the length of stay and improve the experience for elderly patients by the completion of timely frailty assessments and the collaborative working with the local system. Patient journey coordinators were also seen as key to ensuring the patient experience was improved.

Staff raised concerns over the current provision of neurology services at the trust. The service provided though a Service Level Agreement (SLA) with another acute trust. There was a substantive consultant who was supported by an external locum consultant who attended the trust and provided a service across both sites as well as providing a telephone service. Staff felt this was not meeting the needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. However, we were not assured there was a zero- tolerance approach to this within the service. The service had reported 347 mixed sex accommodation breaches between April and September 2023. The majority of these (345) were recorded within the acute medical assessment (AMA) area which was part of the acute medical unit (AMU). This had been due to capacity issues which lead to patients needing to be bedded in this area overnight. The breach comes in the morning when the area resumes its day case activity. The largest number of breaches for this area were in July 2023 which recorded 93 breaches that month. Ward 16 (stroke rehabilitation) also recorded 2 mixed sex accommodation breaches in April 2023. No further information in relation to these breaches had been provided. The service reported 61% of the trusts total mixed sex accommodation breaches for this period. Between April and September 2023, the trust had the 3rd largest number of mixed sex accommodation breaches in the Midlands region according to nationally collected data.

This raised concerns over patients not receiving care which respected their privacy and dignity. National guidance recommends that providers take a zero-tolerance approach to mixed sex accommodation, however due to the numbers reported in a 6-month period, we were not assured this was the approach taken within this service and the trust as a whole.

Medical care (including older people's care)

Facilities and premises were not always appropriate for the services being delivered. During our inspection, meeting the demand for the service were raised by most staff as a challenge. Staff from AMU raised how they regularly provide corridor care due to the demand on the service. A standard operating procedure (SOP) had been put in place to enable 3 patients to be safely cared for within the corridor, however staff working in this area told us they had gone over this previously. In addition to this was the need to bed patients in the AMA overnight when there were no beds for patients to be admitted into. Staff working in the discharge ward acknowledged the current arrangements were not appropriate (the service were run out of 2 areas, 1 of which was the end of a ward). However, staff told us there were benefits for where they were currently located (there was a ramp which ambulances could drive up to, to collect patients) even if the layout was not ideal.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. There were also specialist nurses available to support patients between Monday and Friday.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. The endoscopy service were accredited by the Joint Advisory Group. No concerns were raised over the number of appointments which were not attended.

The service relieved pressure on other departments when they could treat patients in a day. The service had provided patients with transient ischemic attack (TIA) and stroke clinics which were aimed to reduce the impact on other services. The service was also keen to reestablish virtual wards which would have a positive impact on the demand of the service.

Meeting people’s individual needs

The service were inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff in all ward areas were aware of the needs of patients with complex medical and psychological histories and escalated these patients when additional support was required. In addition to this, the service had a system in place to identify patients who were living with dementia by placing a butterfly on the patient at a glance board to identify this. If patients had a confirmed diagnosis, these were a solid picture, however if this had not been confirmed or the patient was experiencing acute confusion or delirium, they would receive the outline of a butterfly. Audit information showed all medical wards at this location scored 100% compliance with the butterfly scheme between July and September 2023.

We observed the dementia specialist nurses reviewing patients and documenting any recommendations to improve patient care in the records. Staff told us they had access to activity boxes which included items to keep patients occupied, however these were not always utilised. We did observe a staff member form the Enhanced Care Support Team providing a patient who they were supporting on a 1 to 1 basis with these items and found them to be very successful.

The trust had developed a learning disability guideline alongside another trust who were also responsible for the acute liaison nurses who provided support to patients with a learning disability at the trust and ensure any reasonable adjustments required were implemented.

Not all wards were designed to meet the needs of patients living with dementia. Areas of concern around the environment and design of some of the wards were still not meeting the needs of patients living with dementia. The most recent patient led assessment of the care environment (PLACE) 2022 found the wards at this location were only 69.7% compliant with the standards of the assessment.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We observed where patients were admitted and required a this is me or patient passport to be completed, however these were not completed or partially completed.

Audit results against the dementia charter did not identify any data had been collected in relation to whether patients had a this is me document or passport in place despite this being a criteria within the audit. The action plan in place for the trust identified the service had self-assessed to demonstrate they were compliant with this measure and regularly conducted audits which included this. The information shared after the inspection in relation to dementia audits did not contain details to confirm the compliance with this.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service was confident they were meeting the accessible information standards which had been a requirement since 2016. Comprehensive details of how they were meeting this standard and had been provided after the inspection. They only area which the trust as a whole were still working on were in relation to the requirement to flag patients who had communication needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets and posters available in languages spoken by the patients and local community. Staff told us there were no difficulties arranging interpreters for patients whose first language was not English. Most information leaflets we observed during the inspection were in English, however, staff were able to access leaflets in alternative languages if required.

Staff had access to communication aids to help patients become partners in their care and treatment. We observed communication aids were readily available for staff to use. Staff told us they had access to communication aids and could approach the specialist nurses for additional resources if required. Staff had access to Makaton healthcare cards to support communication with patients. Makaton is a unique language programme that uses symbols, signs, and speech to enable people to communicate.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most patients told us they were satisfied with the range of food options available to them.

Access and flow

There was a high demand on the service which meant there were sometimes delays in people receiving the right care promptly. There were known challenges with discharges for patients who required on going care.

Managers monitored waiting times. However, information showed not all patients could access services when needed. Performance was monitored and reported through the speciality governance meetings. Information received after the inspection showed many of the medical specialities were below the trust target of 92% for their referral to treatment (RTT) performance. On the admitted pathway, only respiratory medicine was meeting the trust target (recorded as 100%). On the non-admitted pathway, only dermatology was meeting the trust target (recorded as 95.4%). Respiratory medicine recorded the lowest RTT of 44.4%. There were no services which met the trust target for the incomplete pathway.

Managers monitored waiting times and tried to make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. During our first day on inspection, we visited the AMU. The ward appeared to be extremely busy and had a fast turnaround pace. They had an electronic information board which contained details of patients waiting in the emergency department (ED) to be transferred to AMU. In the afternoon there was 42 patients which were waiting in the ED to be transferred. Staff told us these were a steady number throughout the day, and they had already had a number of patients transferred to them. Staff told us the service did not use any models to try and increase the flow out of the ED although staff told us as soon as a patient transferred or was discharged from AMU, they had 30 minutes to prepare for the next patient. Information received after the inspection showed there was a policy (Hospital Full Policy) which staff were expected to follow when the demand on the hospital, especially their ED services exceeded the capacity. The policy also included the actions for staff to take in the event of a critical incident being declared.

On AMU they also had a pathway in place to support an additional 3 patients who could be cared for in the corridor. These were considered an extreme measure due to the risk associated with this. Staff told us there had also been occasions when more than 3 patients were cared for in the corridor. We requested further information after the inspection which showed corridor care on AMU had occurred 31 times in the last 6 months, however there had been no incidents reported where this included more than 3 patients at a time. The standard operating procedure (SOP) which they had in place to support this had a strict criteria identified for who they considered to be suitable to be cared for in the corridor.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff were keen to ensure all patients received their appointments in a timely manner.

The service reported only moving patients when there was a clear medical reason or in their best interest. Staff tried to not move patients between wards at night however, staff told us patients were moved throughout the day, which included during the night. Staff believed although not best practice and not in the best interests of patients, these were at times unavoidable to ensure there was flow through the hospital. Where possible, staff tried not to move patients with cognitive impairments or patients who were living with dementia during the evening due to the impact this had on them.

The service had recently developed a report to monitor the number of patient moves and the timings of these moves, including during the hours of 9pm and 7am. Information showed there had been 6,226 moves between 9pm and 7am between April and October 2023. June 2023 recorded the largest number of patient moves during the night. This information were not site specific.

Managers and staff tried to make sure patients did not stay longer than they needed to. However, there were significant challenges faced within the wider health system which impacted the more complex discharges. Staff on Ward 15 told us they were particularly challenged with some of their patients due to the complexity of the illness they suffered and the requirement for ongoing care. The longest length of stay at the time on that ward was 71 days, however as beds were described as ‘gold dust’ on the ward, they had known the longest length of stay to be a lot higher than this. Wards 10 and 11 had also experienced fluctuating lengths of stay on the ward. Staff on both wards acknowledged the difficulty they experienced around patients who required packages of care which they experienced difficulty with. Information received after the inspection showed the average length of stay was around 8 days for the last 6 months. However, the maximum length of stay for elective patients was recorded as 54 days and emergency patients 298 days during the last 6 months.

We discussed these concerns with the senior leadership of the service. They were aware of the issues the wards were facing and were completing a lot of work to try and improve the capacity of the service, part of this work was to reintroduce virtual wards. However, the challenges being faced were not just as a result on the issues internally and therefore the service leads were working with external partners to identify what other measures could be implemented to improve this. Information provided during the factual accuracy stage indicated the service had continued work on this and virtual wards were now well established. There had also been work on other pathways to support patients to receive care in their own homes, who would otherwise require an admission in hospital. This had included a service which had been introduced to administer antibiotics to patients with respiratory infections and heart failure as outpatients.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff ensured the mental health team and social services were involved with patients who were identified as requiring additional support on discharge from hospital at an early stage. Staff told us there were known delays with packages of care which was why it was important to involve external partners at the earliest opportunity.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. Staff from all wards told us there were known delays with discharges for patients who required ongoing care. Information provided after the inspection showed there were 1,223 delayed discharges from medical wards in the last 6 months. General medicine was the medicine speciality which had the largest number of delayed discharges (507 delayed discharges) during this time.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. Staff tried to ensure patients were only moved between wards for speciality reasons. When patients were transferred, staff ensured detailed transfer handovers were completed for each patient.

Managers worked to minimise the number of medical patients on non-medical wards (medical outliers). Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. There were 9 patients who were considered as medical outliers on the second day of our inspection, with Ward 14 (a gynaecology ward) holding the most of the medical outlier patients. Staff told us there had been a lot of improvements to the way medical patients were managed. Each ward had a designated team assigned to each ward which has medical outliers. Wards hold the details for the contact details of the team to enable swift escalation if there were concerns. Staff also told us they had a criteria for who could be placed on a non-medical ward which was mainly adhered to. If there was a need to go outside of this criteria, senior management would be contacted to approve this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives, and carers knew how to complain or raise concerns. However, information about how to raise a concern was not always clearly displayed in patient areas. Patients told us they felt comfortable raising any issues with the staff caring for them at the time if they had any.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There were 54 complaints received by the service at this location in the last 6 months, some of which had more than 1 area of complaint within them. The main theme from the complaints were around communication, this featured in 30 of the complaints received.

The admission and discharge process, clinical treatment and patient care also featured highly in a lot of complaints, appearing in 22 complaints each. Complaints and formal queries logged with the patient advice and liaison service were recorded on the ward dashboard to enable managers to monitor their complaints closely. Compliments were also recorded on the dashboard as well.

Managers mostly shared feedback from complaints with staff and learning was used to improve the service. Staff told us feedback from complaints was usually shared during ward meetings. We reviewed minutes from meetings and found not all wards had this as a standard agenda item therefore we were not assured staff were always receiving feedback from complaints and the learning which accompanied them.

Not all staff could give examples of how they used patient feedback to improve daily practice. Staff told us they were starting to implement a 'you said, we did' system in relation to any feedback they received including concerns and complaints. This would then demonstrate what action were taken in response to concerns raised. Although staff were unable to provide examples where they had changed local practice in relation to serious concerns raised, we were aware of issues raised previously around under 18s being admitted within adult medicine wards. We observed how this had changed practice within AMU, during each huddle, this was raised as part of a checklist of issues to consider.

Is the service well-led?

Requires Improvement

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

Leadership

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

The medical service were part of the medicine and emergency care division. The division were led by a divisional medical director, divisional director of operations and divisional director of nursing. Divisional leads were supported by deputies or clinical leads for specialities within medicine. Divisional leads were very knowledgeable about their main challenges and risks which were largely around discharges from the hospital. They were focused on the importance of delivering safe care and treatment and continuing to drive improvement across the service. Staff were complimentary about the leadership of the service and their visibility and approachability.

Staff were positive about the executive leadership team. Staff told us they believed the stability of the executive leadership team had been a key part in driving success within the service. The director of nursing were identified as a member of the executive leadership team who were especially key to the improvements made within the service and were seen as an approachable leader.

Medical care (including older people's care)

Junior doctors told us they felt well support by their registrars and consultants and spoke of how approachable they were.

Local leadership was provided by matrons and ward managers. All staff we spoke with spoke positively about their local managers and matrons, and without exception told us they were supportive, approachable, and extremely visible.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with staff. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision and a set of values including quality and sustainability. There were realistic strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed in collaboration with staff.

Objectives for the coming year had been published which aimed on building on the work the trust had completed over the previous few years. The service was aligned to the trust’s overall aims and objectives, especially in relation to the improved flow through the hospitals. The trust released a newsletter for staff to review which included information around the vision, strategy, and key objectives for the trust as a whole.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt valued, supported, and respected by their leaders and by their peers. Staff were aware of the challenges and scrutiny the trust was under and how that had impacted the culture previously. However, staff told us the culture within the service had improved and they were proud to work for the trust.

All staff we spoke with told us the service were patient centred and they were committed to ensuring patients had a safe and positive experience whilst admitted.

Staff spoke positively about their managers and told us they were approachable. Managers gave the well-being of their team’s considerable importance. Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. There were no concerns raised within the service about any types of bullying, harassment, or discriminative behaviours. However, the information on the staff survey from 2022 showed staff had concerns about the diversity, equality, and inclusivity of the service. Only 50% of staff from the medicine and emergency care division believed the organisation acted fairly towards staff regardless of their ethnic background, gender, religion, sexual orientation, disability, and age.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Appropriate learning and action taken because of concerns raised were also important to instilling a learning culture which did not apportion blame on staff. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff were aware of the Freedom to Speak Up Guardian and knew who their guardian was at the trust. Junior doctors were also aware of their guardian for safe working and how to escalate concerns if they had any, however all commented on how happy and supported they felt.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities however there was an inconsistent approach to how staff met to discuss and learn from the performance of the service.

There were governance processes in place within the division which produced detailed information about the division's performance. Service leaders told us they had put significant work into their governance processes and tried to mirror the performance meetings like those of the executive teams. Part of the programme was to include away days to explore future developments to the service, which ultimately filtered down into the divisional and speciality plans.

Speciality meetings were regularly conducted and information from this fed into the wider divisional governance framework. The meetings were mostly standardised in their approach and covered all pertinent governance points.

There were variable feedback in relation to ward/department meetings. Staff told us in most areas these occurred, however they were infrequent. Some staff were unable to remember when their last ward meeting was held and relied upon huddles and notices for important updates. Information received after the inspection showed there had been ward meetings, however there were no consistency in frequency. An example of these were Ward 10 held a meeting in January 2023, but no further meetings since, whereas wards 6, 7 and 9 held meetings in June and July 2023. No information was received for Ward 11. The minutes from the meetings mostly followed the same format, however we observed there were some variations between wards in items discussed. The introduction of safety huddles was not a replacement for ward meetings, however staff were able to receive key updates and important information during these.

Mortality and morbidity meetings took place and fed into the clinical governance meetings. These meetings were attended by a wide range of clinical and operational staff and followed a set agenda.

Management of risk, issues, and performance

Leaders and teams used systems to monitor performance however, we were not assured this was challenged effectively when performance was identified as poor. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

All medicine specialities had their own risk registers which were reviewed at speciality governance meetings regularly. The senior leadership for the service also recorded what the overall division's top risks were. At the time of the inspection there were 22 extreme risks within the division, this included work force, overcrowding and capacity concerns within Acute Medicine Unit (AMU) and consultant challenges within cardiology. There was evidence of all risks being reviewed regularly, even when the risk was accepted due to no further mitigation being available for implementation. We did however observe risks which had been on the register since 2014 and 2017, the risk level had not appeared to decrease from what the risk was originally identified as, and no recent mitigation noted. We were therefore concerned there was a potential for some risks to be overlooked at times. Information provided during the factual accuracy period showed the trust as a whole had worked on their risk processes and had implemented a new process since the inspection which had reviewed and closed older risks. This meant there were no longer risks on the medicine risk register dating back to 2014.

The risk register reflected most of the risks which we identified and which staff told us about. However, we did not see any risks identified by staff as a result of the concern around the lack of an onsite neurology service. Information received during factual accuracy identified this was not deemed as a risk due to the immediate action taken to seek support through a Service Level Agreement (SLA) which the leadership believed was working well. There was also no risk identified in relation to mandatory training and the VTE risk assessments at the time of our inspection.

Within the information provided by the service, we did not see any plans on how they intended to reduce the number of mixed sex breaches. This was not identified within the risk registers as a risk, and this was not identified within any performance data. None of the minutes of the governance meetings identified this as an area for discussion and no measures identified on how this was going to be mitigated going forward. We specifically reviewed the minutes from the acute medicine meetings and stroke meetings as these were the areas which had recorded breaches. We were therefore not assured there was specific oversight of this issue.

The service had nursing quality assurance matrices in place which monitored the performance of wards for a number of nursing related metrics. These were reviewed at matron and managers meetings within the division as well as being reviewed at nursing quality matrix assurance meetings which was chaired by the director of nursing. Areas which were challenged in any of the matrix were held to account during these meetings. We reviewed the results from July and August 2023 and found there were many metrics which showed wards were not able to maintain improvements. An example of this were Ward 7 who achieved 100% compliance with indwelling devices in July 2023, however this dropped in August 2023 to 76%. Another example was Ward 16 who achieved 95% compliance with missed doses audit, however this dropped in August 2023 to 67%. The information also showed there were continued challenges in relation to dementia screening with all medical wards failing to demonstrate high compliance in July 2023, this continued to demonstrate poor compliance in August 2023, however Ward 16 managed to achieve 100% compliance, compared to 60% in the previous month. Despite the reports identifying ward leaders and matrons being held to account over areas with poor compliance, we were unable to triangulate this with the governance reports and therefore were not assured this was being managed with the importance this required.

There were business continuity plans in place to maintain delivery of services in the event of planned or unplanned closure.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to clinical information and systems used to monitor patient care. The service only used minimal systems at this time for monitoring and recording care and treatment, however staff were aware of the plans to develop their information technology systems in the future. Access to the systems in place at the time of inspection was secure and required passwords.

The service collected reliable data and analysed it. Staff told us they had support to help collect reliable data for national audits to ensure accurate collection and submission of the data. The service also ensured there were systems in place to submit required information to external organisations, such as incident data, surgical site infection data and numbers of alert organism infections and the Care Quality Commission (CQC) for notification of Deprivation of Liberty Safeguards applications.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Medical care (including older people's care)

Staff participated in the trusts staff survey. Information from the 2022 survey showed the service scored below the trust average for all key areas. The areas which had the greatest variance were around work pressures and staff reporting feeling safe and healthy. Unfortunately, the information shared after the inspection did not provide response rates for the survey, so it was impossible to gauge how reflective of the service the results were.

The service proactively engaged with stake holders and other partner organisations to ensure service delivery met the needs of the population. At the time of inspection, there were many upcoming opportunities for the service leads to meet with external stakeholders about the discharge challenges. This gave all parties the opportunities to discuss sensible options to how this can be managed, especially in light of the winter months approaching and the expectation for the challenges to worsen.

Staff recognition awards (star cards) were now in place to recognise staff who were going above and beyond to help improve services for patients and the experience they have when they were admitted.

The service held a monthly patient experience group meeting. These meetings were identified as a positive forum for helping to improve how the service was run. One area which was a focus of the group were in relation to the transformation of the service which had also included feedback from focus groups around this as well. An action plan of points raised were formulated and reviewed regularly to identify where progress was made.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services and improvements from the previous inspection had been noted. However, staff were aware there were still improvements to be made.

Staff of all roles were positive about ways in which improvements could be made in the delivery of the service. They believed they would be supported to take these ideas forward. We saw examples of how staff had been involved in improvement programmes, which included Ward 10 which had completed a project on reducing the length of stay for patients admitted on the ward.

During this inspection, we observed there had been improvements since the previous inspection in 2021. The quality of record keeping and the risk assessments as a whole had improved. The pace of improvement appeared proportionate to the level of concern identified during the previous inspection. All staff recognised that although improvements had been made, there were still work to do, an example of this was around the Sentinel Stroke National Audit Programme. Staff had already made some improvements, however there were areas which staff reported had some barriers and were now looking at how to navigate these barriers. There were also other areas which we observed during this inspection which appeared to have worsened. Practice around Venous Thromboembolism (VTE) risk assessment appeared to have worsened since the previous inspection. Information demonstrated these were areas which the trust as a whole were working on, not just the service, to ensure there was a process in place which ensured patients in all areas had an accurate and timely VTE risk assessment completed and actions taken according to the outcome of the risk assessment, as opposed to the automatic action being taken regardless of what the risk may be.

Urgent and emergency services

Inadequate

Is the service safe?

Inadequate

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

Mandatory training

The service provided mandatory training in key skills, including the highest level of life support, training to all staff and made sure everyone completed it.

Nursing staff were mostly up-to-date with their mandatory training. The trust provided us with a breakdown of medical and nursing staff completion of mandatory training. Overall, compliance with mandatory training was 89% which was slightly below the trust's target of 90%. However, nursing and medical staff at urgent and emergency care at The Princess Royal Hospital were compliant with the trust's target for this training in 12 out of the 21 modules.

All band 6 and band 7 staff were required to complete advanced paediatric life support training as per standard 13 of the Standards for Children in Emergency Care Settings. Twenty-three out of 24 staff had completed this training. A staff member was awaiting a place to undertake the European advanced life support training. Compliance for this training module was at 96%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety awareness, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The emergency department had education leads in order to facilitate and maintain improved access to training.

Safeguarding

Not all staff understood how to protect patients from abuse. However, they had training on how to recognise and report abuse and mostly knew how to apply it.

Staff did not always follow safe procedures for children visiting the department. The service had a flagging system to enable staff to raise safeguarding concerns. Safeguarding children nurses visited the department daily and reviewed all paediatric casualty notes and checked all vital information had been completed. However, during our inspection, we saw an example when staff had not raised a safeguarding referral with other agencies to safeguard a child and ensure a safe discharge. The child had attended 3 times within 2 months and concerns had been raised, but there was no

evidence of actions being taken by staff. We were concerned there was a risk safeguarding information had been missed and there was a risk of key information not being shared with other professionals involved in plans to safeguard the patient from harm or neglect. We raised this with senior staff who took necessary steps to ensure the missed opportunity was actioned.

Staff carried out audits of completed safeguarding referrals. From October 2022 to September 2023, 21,465 children attended the emergency department (ED). The total number of child safeguarding referrals made by ED in the 12 months before our inspection, was 938.

We reviewed the minutes of the safeguarding children operational group meeting which was held in July 2023 and found staff discussed an increase in the number of children attending the ED and staff attended partnership meetings.

Staff mostly knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We observed a safeguarding adults liaison nurse visit the ED to check if there were any adults with safeguarding concerns. Safeguarding liaison nurses for children and maternity also attended the department daily.

The trust had policies in line with national guidance. Staff received training specific for their role on how to recognise and report abuse. Data provided by the trust showed that divisional training compliance for safeguarding was 94% and compliance figures were all above trust targets for safeguarding adult and safeguarding children training in levels 1, 2 and 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff professional standards of practice and behaviour were underpinned by values of equality and diversity. This meant staff treated people as individuals, avoided making assumptions about them, recognised diversity, and individual choice, and respected and upheld their dignity and human rights.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. For example, when patients had complex social care needs or staff identified potential safeguarding risks at home, they liaised with the safeguarding team and other multidisciplinary colleagues to ensure patients were protected. We saw completed examples of safeguarding referrals during inspection.

Children had their own assessment area pathway within the department. All paediatric patients we saw in the area were accompanied by their parents and carers.

Staff knew how to identify and refer children and young people at risk of female genital mutilation.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff were inconsistent with the use of control measures to protect patients, themselves and others from infection. However, equipment and the premises were visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). The ED had a respiratory isolation unit (RIU) which was called the ‘red zone’. It had 2 cubicles which were used to care for patients with suspected airborne respiratory diseases. Staff attending these areas were required to wear specific PPE.

We witnessed 5 staff caring for patients with suspected air-borne respiratory diseases within the RIU with no PPE. This posed a risk of cross contamination. We raised this with senior staff at the time of our inspection who alerted staff about the need to wear PPE in the area. However, throughout our inspection, we saw inconsistency of staff with or without PPE in the red room. This had been raised as a concern during our last inspection.

The service had adequate supply of gloves, aprons and alcohol gel and most staff had their arms bare below the elbow. However, we saw 5 staff wearing jewellery within clinical areas where patients were being cared for. This posed a risk of contamination as they can harbour microorganisms and made hand hygiene less effective.

We reviewed the Friends and Family Test results, and the majority of respondents observed the nurses (99.5%), doctors (98%) and healthcare professionals (99.4%) wash their hands before caring for them.

We observed waste being managed in an escalation area, including a vacuum cleaner being emptied in patient facing areas posing a risk of contamination. We also observed domestic staff wheeling a large yellow industrial wheely bin with a hazard sticker into the waste cupboard located in the escalation area which had 5 patients. The waste cupboard was situated between 2 beds being used by patients which was an inappropriate escalation area.

Infection prevention and control (IPC) was a mandatory training module. Figures provided by the trust following our inspection showed 97% of staff were compliant on IPC level 1 training. Medical staff compliance for IPC level 2 was at 87% and 80% for non-medical staff and this was slightly below the trust's target of 90%.

All areas were clean and had suitable furnishings which were clean and well-maintained. We checked equipment and furniture including chairs and ECG machines. These all appeared clean and dust free.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to identify when an item of equipment had been cleaned was ready for use.

National guidance on IPC measures for COVID-19 had changed since our last inspection. The trust followed the latest guidance. Hand sanitising stations were placed at entry points throughout the department, and we observed people using these.

The service generally performed well for cleanliness. Managers actively supported staff to improve on IPC. Figures for the IPC quality walks from April to September 2023 identified that the compliance with hand hygiene audit was at 79%. The service had an action plan in place which detailed the issues identified and actions required to improve compliance.

We requested details of the hospital's patient-led assessments of the care environment (PLACE) scores. PLACE scores are the outcome of annual patient-led assessments of how the environment supports the provision of clinical care. The assessment includes the cleanliness and general building maintenance of each department. The results of the assessment we were shown from 2022 confirmed the department had passed the assessment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The trust had adapted a room which complied with the July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department (ED) Care standards which recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. The mental health room was free from ligature points and had a separate door for staff members to exit in the event of an emergency. The door clearly stated; 'emergency exit, do not block door'. However, this door was locked and also blocked from outside with a drip stand and equipment. This did not comply with statutory requirement and posed a potential risk to staff.

Patients could reach call bells and staff responded quickly when called. However, we found 3 patients in the ambulance receiving area did not have a call bell, and all 5 patients in the escalation area did not have call bells. Call bells were available in the main ED corridor, dedicated staff were allocated to those areas and were visible to patients. The nurse in charge carried out regular rounds within the ED. An emergency call bell was located on the corridor which was normally a public corridor. Although there were no wired call bells in the escalation area as it was normally a public corridor, the area was always supervised by 1 registered nurse and 1 healthcare assistant.

The Friends and Family Test feedback revealed 97% of patients said the nurses answered the call bell promptly when it was used.

The design of the environment followed national guidance. The paediatric ED had a separate area with 2 separate paediatric triage rooms. A 'fit to sit area' available and was mostly used for patients waiting for bloods to be taken. A recliner area was also available for patients awaiting medical beds and bloods. A nurse was allocated to care for patients in the recliner area.

The emergency department had 3 cubicles. Two of these cubicles were used for assessing medical patients and one was used as an isolation area.

Staff carried out daily safety checks of specialist equipment. There were arrangements for enhanced cleaning. We reviewed safety checks on all resuscitation, airway and sepsis trolleys. All were checked as per the trust policy and included all relevant equipment.

The service did not always have suitable facilities to meet the needs of patients. During day 1 of our inspection, the passageway outside the urgent and emergency care service leading to other areas was used as a new escalation area with 5 beds in the morning. The area had screens to stop staff, patients or members of the public from using it as a passageway, but it was still being used as a general hospital passageway for staff to move patients to various areas of the hospital. This area was cramped, had no toilet facility, or plugs which meant staff were unable to connect drip pumps and nebulisers. A patient who received care in that area was unable to receive their nebuliser and had to be moved as their oxygen saturation levels dropped. This meant patients were at risk of deterioration due to potential delays in receiving lifesaving medication. We raised this with senior staff who told us fluid infusion pumps run on solely battery and smaller infusion pumps had a battery life depending on the flow rate of what infusion was being delivered. However, there were plans to increase the availability of 3-pin sockets in these areas so mains electricity equipment can be used to treat patients who unexpectedly deteriorate.

There was a standard operating procedure for the use of the corridor which detailed the criteria for cohorting patients. The exclusion criteria included but was not limited to patients requiring oxygen therapy, no patients with early warning scores above 2, or who required continuous cardiac monitoring, and patients at risk of falls. However, we observed a patient who had been assessed as being at risk of falls attempting to climb out of their bed (with attached bedrails) in the escalation area. No specific risk assessment for the use of bedrails was found in the patient's record we reviewed.

The service had enough suitable equipment to help them to safely care for patients. Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with tamper evident tags. Safety checks were carried out daily.

Staff disposed of clinical waste safely. Needle sharps bins were available throughout the ED and most of the bins we inspected were labelled and stored correctly.

We found substances subject to Control of Substances Hazardous to Health Regulations requirements stored in an unlocked room. For example, a bottle of mixed disinfectant solution including disinfectant tablets left in an unlocked sluice which posed a risk of unauthorised patients ingesting the solution. We raised this with senior staff at the time of our inspection who said they would consider safer storage options.

Assessing and responding to patient risk

We were not always assured there was adequate oversight and responsibility of the patients who were waiting to be seen. Overcrowding and lack of flow through the ED contributed to delays in identifying and acting upon patients at risk of deterioration. However, information provided at factual accuracy stage showed actions the trust had taken following our inspection to improve overcrowding, flow, and patient safety.

National guidance relating to the initial assessment of patients who presented at the ED was not always followed. The Royal College of Emergency Medicine national guidance states patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment. At the time of our inspection, 17 out of 20 patients had not been triaged by a triage coordinator/nurse within 15 minutes. This concern had been raised during our last 2 inspections in 2019 and 2021 and the trust was served a section 31 condition on their registration to ensure they maintained the 15-minute standard. However, the trust continued to not meet the condition on their registration which was evidenced through monthly data provided by the trust. Information from September 2023 showed compliance had been inconsistent over the previous 5-week period, with the lowest at 21.3% and the highest compliance at 55%. Compliance continued to be inconsistent in October 2023, with only 37% of patients being triaged within 15 minutes from the 1 to 10 October 2023. The trust had plans to introduce electronic screens to display waiting times in waiting rooms, this would help inform patients about alternatives to ED and improve general communication. Although the nurse in charge had general oversight of patients who exceeded the 15 minutes standard and escalated them, compliance remained poor.

Information provided to us during the factual accuracy period showed the Trust had continued to focus on improvement through its Emergency Transformation Programme of improvement work implementing a number of improvements which had led to an improvement in compliance of the 15-minute triage standard with approximately 48% of patients now receiving their initial assessment within 15 minutes.

During day 1 of our inspection, we witnessed 7 ambulances holding patients outside of the department. Most of these patients had been waiting for over 4 hours, including 2 patients who had chest pain with previous cardiac issues but had not been assessed by a doctor. As diagnostic tests, for example blood tests, were not being performed and so there was a risk of patients with deteriorating conditions not being recognised. However, patients were being monitored by the ambulance paramedics who had given handover and told us they would escalate any patients immediately if signs of deterioration were noted. Senior staff said patients who had been waiting over an hour on an ambulance would be reviewed by a clinician, but the patient records we looked at showed the patients we saw had not been assessed by a doctor in that time period.

Ambulance staff pre-alerted the ED staff about seriously ill patients who were on their way to the department and who were potentially in need of urgent treatment. ED staff made arrangements to receive them which included identifying the right clinical professionals to be available to treat them. For example, on day 2 of our inspection, we observed specialists from the stroke team waiting for a patient who was on their way to the ED.

The trust employed a navigator who was a paramedic and liaised with ambulance crews and the nurse in charge to ensure patients were prioritised appropriately and helped provide efficient ambulance offload and turnaround.

The service had a standard operating procedure for the use of additional spaces within The Princess Royal Hospital and Royal Shrewsbury Hospital to reduce the likelihood of prolonged (in excess of 30 minutes) ambulance waits outside of the ED. This was to optimise timely handover of patients arriving by ambulance and to support executive decision making once the hospital full policy had been activated, and when there were significant ambulance off load delays. The decision to implement the use of additional space within the ED's would be made by the emergency Physician in Charge and Nurse in Charge at both sites, in conjunction with the navigator nurses and required approval by a member of the executive team.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a national early warning score (NEWS2) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. This ensured early intervention from skilled staff. We checked records and found all 32 records had evidence of NEWS2. Patients were appropriately escalated and treated according to sepsis guidelines in all 8 sets of notes we reviewed for this purpose. The NEWS2 was calculated using a handheld device for recording patients' vital signs. This was then available on the department dashboard for clinicians to see immediately, increasing the oversight of potentially seriously ill patients.

Staff carried out NEWS2 audits to review documented evidence that NEWS had been acknowledged and escalated according to trust policy. Audits revealed compliance of 86.7% in July 2023, 88% in August and 97.2% in September with an overall compliance of 90.6%. The service had an action plan in place to improve on compliance.

The department also used the paediatric early warning score (PEWS). The PEWS tool was developed by the Royal College of Paediatrics and Child Health. Staff in all areas completed these observations, including a pain score, in accordance with trust policy, and staff knew the escalation process for patients who had a high score.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The receptionists gave cards to patients who presented with a chest pain. These patients were prioritised and received an initial assessment and staff carried out electrocardiograms and took bloods.

Staff knew about and dealt with any specific risk issues. Staff used an assessment booklet which contained for example, assessments for sepsis, falls, mental capacity, frailty and skin integrity. Staff used the completed assessments to inform care delivery.

An ED patient safety checklist had been introduced to increase documentation of specific care requirements during a patient journey through the department. The document identified specific tasks that should be assessed during each hour of the patients stay, including understanding of the care plan, dietary and refreshment needs, pain relief and access to a call bell. All patient notes we reviewed had one of these checklists.

Staff followed a sepsis pathway to assess patients who triggered as at risk. In records we reviewed, staff had used this pathway appropriately. There was a designated doctor who responded to sepsis issues daily. Staff agreed on who would be the sepsis bleep holder during the doctor's board rounds, the bleep holder was required to respond within 5 minutes of a bleep.

Compliance with sepsis screening and treatment was routinely audited. Following our inspection, staff shared sepsis audits they had undertaken from July to September 2023. The audit results revealed 92% of patients had received intravenous antibiotics within 60 minutes of identification of sepsis. The service had an action plan in place which was implemented and detailed actions to take to improve compliance with NEWS2, this included sepsis training.

Information shared with us following our inspection showed 8 nursing and medical staff were up-to-date on the advanced life support training, 2 senior nurses were up-to-date on paediatric immediate life support training and 20 medical and nursing staff were up to date on the European paediatric advance life support training. We were unable to determine the level of compliance as the trust only shared the number of staff who had completed the training. However, information provided to us following our inspection showed the service ensured every shift had either two registered children's nurses or registered nurses with paediatric competences.

The ED had a recent trial of yellow blankets as a visual cue for staff that a patient may be at risk of falls. This had increased staff awareness and flagged up the need for further interventions to mitigate the risk of falls. A falls awareness week took place inSeptember and included activities on training sessions to raise awareness of falls risk.

The service had 24-hour access to mental health liaison and specialist mental health support. The ED did not have any mental health nurses. However, the mental health team was based on site and could be contacted from 9am to 6pm and the crisis team was available overnight. The mental health team had a patient liaison nurse daily to 8pm or twilight shift to 2am. Staff told us the mental health team patient liaison nurse carried out triage assessments within 1 to 2 hours of the referral being sent.

Senior staff mitigated risk by using a healthcare assistant to carry out one-to-ones. Healthcare assistants had specific mental health training and a session on mental health training conditions and staff had panic alarms in the mental health room.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The mental health specialist team provided a variety of services including advice on alcohol problems, substance misuse treatment and assessment of care needs of older people living with mental health problems.

Staff shared key information to keep patients safe when handing over their care to others. Staff held 2 hourly huddles where patients' clinical status and management plans were discussed, and early warning scores noted. This huddle consisted of the senior nurse on duty and the emergency physician in charge (EPIC). Where a patient's clinical condition had changed an alternative space would be identified within the department and the patient moved to a more suitable space.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers ensured safe continuity of information between shift changes and improved communication with patients and families.

The waiting areas became crowded during busier times. Clinical staff carried out a visual assessment of all patients. However, long waits still posed a risk to patient safety.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications and training. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. On the day of our inspection, we reviewed staffing rotas and saw that the actual count of nursing staff in the ED matched the planned staffing count. Gaps were covered by agency staff and staff who had been moved from other ward areas.

The nurse in charge (NIC) moved staff depending on the demands of the department to ensure areas in peak demand were provided with additional staff to maintain patient safety. If the department was unable cover any staffing shortfall, staffing across the division on the site was reviewed and staff moved accordingly. We spoke with staff who had been moved from other areas to provide cover.

The number of nurses allocated to care for the patients on the corridor was variable and allocated by the NIC depending on skill mix and competence. This could be nurses from ED, those who were redeployed from the ward areas (medicine, surgery and the acute floor) or temporary staff. Staff discussed the identification of staff to support ED and additional escalation areas via the twice daily staffing meetings.

The department was supported by emergency and advanced nurse practitioners whose shifts were staggered throughout the day.

Not all staff were able to take regular breaks. For example, 2 staff members told us they had worked prolonged hours without taking any breaks including one who was yet to have a break 8 hours into their shift. They said this was common practice and did not feel the need to raise it as an issue. However, the Trust were aware of the issue and had included this as a focus area as part of their transformation programme work.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Current staffing requirements were calculated using a recognised staffing tool. The Royal College of Emergency Medicine (RCEM) Baseline Emergency Staffing Tool was used alongside an adapted tool supported by NHS England and emergency care improvement support team that had formed the foundation for the 2019 workforce review paper.

The ambulance receiving area (ARA) had 8 patients on trolleys. The patients were cared for by 3 nurses and 2 healthcare support workers. Doctors were also based in the ARA.

The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings.

The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers. We observed a nursing handover from the night to day team, it was organised and covered relevant information. Staff were allocated based on skill mix.

The service had reducing vacancy rates of 6.7%. The total nurse staffing position 227.88 whole time equivalent (WTE) worked against a budgeted establishment of 186.75 WTE. The service undertook recruitment campaigns to fill vacancies and had recruited international nurses who were due to commence working to the trust in December 2023.

Urgent and emergency services

The service had high turnover rates of 12.6% with the target to get to 11%. Work had continued with retention groups to understand reasons why staff were leaving.

The service had increasing sickness rates. The sickness rate for qualified nursing staff in urgent and emergency care at the trust increased from 5.4% in January 2023 to 7.7% in June.

The sickness rate for healthcare assistants in urgent and emergency care at the trust increased from 4.9% in January 2023 to 13.7% in May. In June the sickness rate fell to 7.5%.

The service had reducing rates of agency nurse use.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers used bank and agency staff to care for patients in the escalation areas, corridor care and to support the ambulance receiving area. These staff were overseen by substantive staff.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with agency nurses that booked block periods of time in the department to ensure continuity for the patients and the team. All agency and bank staff had local induction and access to the trust systems and handheld devices to ensure observations could be taken and uploaded in a timely way.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The trust was commissioned to provide type one and type 2 emergency care services across 2 acute locations, Royal Shrewsbury Hospital and The Princess Royal Hospital. Consultant WTE was at 12.42 WTE at the time of our inspection against 15.92 budgeted WTE and the number of medical staffing was at 58.6 WTE slightly below the budgeted WTE of 59.

The medical staff matched the planned number. Consultant cover in the adult ED was in line with RCEM which recommends consultants provide 16 hours of cover in the department. Consultants were typically present in the adult ED from 7:30am to 12pm, 7 days a week. A consultant was on call (provided off-site cover) at all other times.

Consultants were supported by a team of junior doctors. Middle grade doctors worked on overlapping shifts as did the foundation year doctors in the department. All junior staff reported that they had enough staff per shift. We saw the daily allocation board for medical staff and noted no gaps in the rota.

The service had reducing vacancy rates of 6.8% for medical staff. There was a rolling advert for emergency care consultants.

The service had low turnover rates of 5.4%. Work had continued with retention groups to sustain these low turnover rates.

Sickness rates for medical staff were low. The staff sickness rate for medical staff in urgent and emergency care at the trust has been the lowest over the last year from April to June 2023 (2.1% to 2.7%).

The service had reducing rates of locum staff.

Managers could access locums when they needed additional medical staff. The locums used were regular doctors who had worked in the service for some time.

Managers made sure locums had a full induction to the service before they started work. Processes were in place to ensure locums understood the trust's systems to make sure they could deliver safe, effective and efficient care to patients.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We saw good examples of skill mix on every shift we observed during inspection.

The service always had a consultant on call during evenings and weekends. We saw that consultant cover met national guidance for overnight and weekend cover.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, they were not always stored securely.

Records were not always stored securely. We observed 5 patient records left on a table in the escalation area and also found 2 trolleys left unlocked in majors. There was a potential risk of breach of information governance as these records could be accessed by unauthorised individuals.

Patient notes were comprehensive, and all staff could access them easily. Records were a combination of electronic and paper records. Tools and templates were available for staff to use to aid their assessment of patients. We found they were fully completed in most records we reviewed.

When patients transferred to a new team, there were no delays in staff accessing their records. These were taken with them for direct handover from the emergency department staff.

Staff sent discharge letters to GPs and informed health visitors where patients had attended the ED.

Medicines

The service mainly used systems and processes to safely administer and record medicines. However, medicines were not always prescribed and stored safely.

Medicines storage was locked and secure with access only to authorised staff. However, medicines were not always managed or stored safely. In resus, we observed disorganised storage arrangements with loose strips of medicines not in their original containers, tablets and liquid medicines stored together and no coordinated system in place to easily locate a medicine. There was a disorganised system of top up. We were told that medicines were taken from the clinical utility medicine store to top up resus medicine cupboards with no overall oversight. This increased the potential risk of a medicine error, or a medicine not being located. There was a lack of individual staff responsibility to ensure that medicines were stored safely or neatly. The latest Safe and Secure Handling of Medicine audit also identified the same issues of poor storage and lack of staff accountability. An action plan was in place to increase pharmacy involvement to top up medicines directly to resus with a target date of 30 November 2023.

Urgent and emergency services

A patient who was admitted following a medicines overdose and at risk of self-harming had been left with their own medication posing a risk of drug overdose. The medication was removed at the time of our inspection. We raised this with senior staff who said any medication brought into hospital would be isolated from the patient if they were found to lack capacity. The risk would be identified via the mental health triage, and this would trigger a mental health assessment where appropriate. In this instance, the patient had mental capacity. Staff acknowledged the right processes were not followed. Immediate actions taken included discussing the case during staff huddles and cascading the patient search policy.

Following our inspection, we requested for risk assessments used for patients presenting with the risk of self-harm. Staff said they used the Manchester Triage System to electronically carry out risk assessments. The system categorised patients into risk categories and any patient who triggered risk of self-harm had a mental health triage form completed and submitted. We reviewed the mental health triage form which clearly had questions around any recent self-harm and if the patient had been searched for medicines by the triage nurse.

We found a loose antibiotic ampoule in the treatment room within the majors area. We raised this with senior staff who ensured this was locked away immediately.

Refrigerator temperatures were recorded. However, records showed that the temperature for the clean utility refrigerator was above the safe range for medicine storage for eleven consecutive days between September and October 2023. Staff had failed to take any action. This increased the risk of medicines not being effective due to incorrect temperature storage and did not follow the manufacturers guidance for safe medicine storage. The latest Safe and Secure Handling of Medicine audit had identified the same issue. An action plan had been put in place for staff to receive education on how to action temperature excursions with a target date of 30 October 2023.

Controlled drugs (CDs are medicines requiring more control due to their potential for abuse) were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff twice a day. Checks of CDs showed that they were within date and stock balances were accurate.

Resuscitation medicines required in an emergency were stored in tamper-evident boxes which followed Resuscitation Council (UK) guidance. Staff recorded safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Staff did not always follow systems and processes when safely prescribing, administering, and recording medicines. During our inspection, patients had not been prescribed their regular medication after a prolonged period in ED in 4 out of 7 charts we reviewed. This included a patient waiting to be moved to the acute medical unit with no drug chart for over 12 hours.

Medicines were delivered from pharmacy twice a week which ensured medicines were available. If there were any medicine shortages or non-availability the pharmacy provided advice regarding alternative treatment options. Staff knew the routes to obtain medicines out of hours if required.

Staff routinely recorded allergy status on all medicine records seen. This meant that allergies were highlighted so medicines could be prescribed safely.

Urgent and emergency services

Staff were able to review patient's medicines and provide specific advice to patients and carers about their medicines. Doctors mostly reviewed patient's medicines on admission to the emergency department which was documented in patients notes and on medicine charts. We saw an example where a doctor had reviewed and stopped a patient's medicine for 2 days. The reason was documented in the patients notes. We spoke with the patient who confirmed that the doctor had given a clear reason and explanation for stopping their medicine.

We reviewed the Friends and Family Test (FFT) feedback and patients confirmed their wristband was checked before administering any medication (95.6%). Respondents also said their medication had been fully explained to them (94.8%).

Staff mostly completed medicines records accurately and kept them up to date. Documentation of medicines administration including routes of administration and specific times of administration were completed on the medicine records reviewed.

Staff followed current national practice/guidance to check patients had the correct medicines.

Doctors within the emergency department undertook medicine history reviews. This ensured patients medicine records were up to date before they were admitted or moved between services.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The sepsis screening tool was completed and antibiotics for treating sepsis prescribed when appropriate.

Dedicated sepsis trolleys were available for the immediate treatment of sepsis including a dedicated paediatric sepsis trolley. These were checked daily to ensure the medicines were available and in date and therefore safe to use. A sepsis pathway was available with each sepsis trolley. This helped to ensure that staff could follow the National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes of a diagnosis of suspected sepsis.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents would be shared across the trust.

Medicines charts carried yellow stickers which stated, 'people with Parkinson's disease need their medication on time every time. There was a 'get it on time' note to alert staff and enable them administer time critical medication for Parkinson's disease in a timely manner. We saw staff set an alarm to remind them on when to administer this medication.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Decision making processes, including a mental capacity assessment, were in place for staff to follow if a medicine was administered to manage agitation or aggression (rapid tranquilisation). A rapid tranquilisation (RT) policy was available specifically for the emergency department which staff could tell us about. RT was reported as an incident which was then checked to give assurance that it was used appropriately and safely.

The service had a general activity risk assessment for the use of oxygen cylinders where patients did not have access to medical gas pipeline systems, for example, patients receiving corridor care. This provided guidance around the hazard, current and additional risk control measures staff should take in all areas.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff gave examples of incidents they had reported, confirming this. This included patient falls, safeguarding concerns, medicine incidents and patients displaying aggressive behaviour. Staff reported 3,629 incidents over a 12-month period up to October 2023.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff knew how to reports incidents though the incident reporting IT system. Incidents reported included those where the incident had occurred before arrival such as community acquired pressure sores.

From 9 September 2022 to 8 September 2023, there was 1 never events under Accident and Emergency at this trust. One never event was reported at The Princess Royal Hospital which was categorised as wrong site surgery and was a wrong side chest drain insertion.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to tell us about incidents that may influence the care they provided.

Staff reported serious incidents (SI) in line with trust policy. Between September 2022 and September 2023, the trust reported 27 SIs in urgent and emergency care. Thirteen of these incidents related to diagnostic incidents, including delay meeting the SI criteria (including failure to act on test results), 7 of them were around slips/trips/falls, 6 around treatment delay meeting the SI criteria and 1 was a surgical/invasive procedure incident meeting the SI criteria.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The providers policy for the reporting and management of incidences instructed staff to be open in an honest, report incidents in a timely fashion, and ask patients and relatives if they had any questions they would like answered in an investigation.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Staff gave an example of learning following a fall of a patient living with dementia who had sustained a fracture. Following this serious incident, staff were required to complete a mandatory falls risk assessment, there is now a general reminder at the daily huddle and staff are encouraged to complete and incident form online with a no blame culture.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed root cause analysis (RCA) investigations to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. The purpose of an RCA is to improve patient safety.

Managers debriefed and supported staff after any serious incident. Staff said local managers were supportive and they would debrief staff after involvement in incidents such as a traumatic resuscitation.

The service had a major incidents board. Staff partook in a major incident day with other blue light teams such as police and fire departments to practice major incidents.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had comprehensive policies, procedures and guidance which were aligned with that of national bodies such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. We reviewed a sample of policies and found these were in date and referenced appropriate guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not encounter patients who were subject to the Mental Health Act, but staff were aware of the code of practice and the policies that were in place.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patient records reviews showed that patients' psychological and emotional needs were recorded.

The service had processes in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff told us they followed the trust's Equality, Diversity and Inclusion policy when making decisions.

Patients' physical, mental health and social needs were mostly fully assessed. Staff screened patients for pressure ulcers, falls, venous thromboembolism (VTE) and mental capacity throughout their admission. Practice was in line with the NICE Guidelines CG92 (Reducing the risks for patients developing venous thromboembolism in hospital), QS86 (Falls in older people) and CG179 (Prevention and management of pressure ulcers). The trust carried out VTE assessment audits. From April to September 2023, the trust's pre-validation data showed 86.41% compliance for the medicine and emergency care division.

The service followed NICE NG51 Sepsis: recognition, diagnosis and early management guidance and carried out ongoing local audits to monitor trust progress.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious and cultural needs.

Urgent and emergency services

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients could choose from a wide range of foods that accommodated clinical needs, religious needs and personal preferences to promote eating. Every patient to whom we spoke was complementary about the quality and choice of the food that they were served. We observed patients receiving food regularly at mealtimes, as well as food and drink being provided when requested.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff had access to fluid and hydration charts in the departments and used them where necessary. We saw completed fluid balance charts to monitor fluid input and output, for patients receiving intravenous fluids.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. We observed staff supporting patients who needed assistance with eating and drinking. At the time of inspection, 98% of nursing staff had attended the nutrition and hydration training.

Specialist support from staff, such as dietitians and speech and language therapists was available for patients who needed it. Staff knew how to make referrals to therapists if they were needed. These would mostly be utilised once patients moved to another area of the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff assessing patients' pain at regular intervals and saw evidence of this in patients' records.

Patients received pain relief soon after it was identified they needed it or they requested it. We observed patients getting pain relief when it was requested. The Friends and Family Test feedback revealed 98.4% of respondents said their pain had been addressed.

Staff prescribed, administered and recorded pain relief accurately. We saw no errors or omissions in any medicine charts that we reviewed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. This included participation in the following Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Infection Prevention and Control 2021
- RCEM Audit: Mental Health (Self Harm)
- RCEM Audit: Care of Children in the Emergency Department
- RCEM Audit: Dementia

Urgent and emergency services

Outcomes for patients were positive, consistent and met expectations, such as national standards. The trust shared the local report August 2023 of the National Audit of Dementia which identified 87 patients with a total selected sample size of 80 patients. The percentage of people admitted to hospital with dementia for this trust was at 3% compared to national average which range between 0.1% and 15%. The percentage of people with personal information documents at their bedside was at 95.3% against national average of 46%. The results revealed that 76% of staff had received tier 1 training compared to 86% nationally and 56% of staff had received Tier 2 training compared to 45% nationally.

Managers and staff used the results to improve patients' outcomes. Action plans to improve performance were in place and were updated and discussed regularly within the clinical teams. Junior doctors participated in audit data improvements and this formed part of their clinical education. Band 7 nurses led small teams of staff within the department to focus on specific improvements in care including sepsis management, complaints and tissue viability.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Regular local quality audits were undertaken in the emergency department (ED) and the results were fed back into the trusts internal quality assurance systems. Externally reported audits were completed as required.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from audits. Audit results were discussed locally within the department, divisionally at quality meetings, and trust wide at board level.

The service had a lower than expected risk of re-attendance than the England average. The percentage of patients that reattended the ED within 7 days of a previous attendance was consistently lower than (better) the England and regional averages from June 2021 to May 2023. From September 2022 to May 2023 the trust's percentage was between 5.5% and 6.3% while the England average was between 8% and 8.7%.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they had sufficient training and support to care for patients.

Managers gave all new staff a full induction tailored to their role before they started work. Nurses spoke highly of the induction process which had been developed based on staff suggestions for improvement. They told us it was very thorough, and they were given time to settle into the department and work a supernumerary period before being counted in the nurse staffing figures with suitable supervision and a buddy system in operation.

The service had a competency document which was based on the National Curriculum and Competency Framework Emergency Nursing (level 1) RCN (June 2017) Emergency Care Clinical Domains caring for children and young people. Registered nursing practitioners who undertook the care of infants, children and young people up to the age of 16 years across Shrewsbury and Telford Hospitals NHS Trust (ED were required to demonstrate the knowledge, skills and understanding in order to deliver safe, effective and timely care to patients. At the time of our inspection, 60% of registered nurses had attained paediatric competences. The figures did not reflect new staff who were still supernumerary and staff on maternity leave.

Substantive staff who supported the escalation areas in ED received a local induction of where key equipment was located. There was an ED induction checklist for temporary staff to complete which also included the name of the nurse in charge to enable them to know who to escalate concerns to.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal completion rate was 89.6% which was very close to the target of 90%. Staff had access to ongoing one-to-one support development conversations.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. They encouraged staff to develop into different roles which supported the overall running of the department.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high-quality training which covered their learning needs. Feedback from junior doctors about their experience and access to clinical supervision in the department was extremely positive. Staff we spoke with told us they had seen improvements in the department and had decided to stay. A number of medical staff were also now taking up training posts within the region.

The clinical educators supported the learning and development needs of staff. There was a practice education facilitator who supported all internationally educated nurses and all new starters. New starters had a 4 to 8 weeks supernumerary period until they were comfortable to work on their own.

The service had a buddy system in place. International staff worked work as preregistered staff for clinical experience and wore pre-registered nurses' armbands to enable other staff recognise their status.

Senior leaders had processed applications for 5 band 5 nurses to start a university postgraduate certificate in September. Emergency nurse practitioners had been given opportunities to attend external courses such as minor surgery and pain relief.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meeting minutes and outcomes or actions were shared with all staff via email, social media or by a dedicated staff app. Staff meetings could be attended in person or using video conferencing facilities. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds. Board rounds occurred twice daily at 8am and 4pm respectively.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Senior medics told us they provided clinical supervision to their junior staff members.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were positive about this experience.

Managers identified poor staff performance promptly and supported staff to improve. A professional nurse advocate ran monthly clinics to support staff quality improvements.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily huddles around the white board (a screen which displayed information taken directly from patients' electronic record) included all disciplines of staff.

Leaders described how they worked closely with the medical division to improves medical reviews and access onto a medical ward if required. The frailty team facilitated patient journey and were active in supporting staff and patients in the ED. The team consisted of occupational therapists, physiotherapists and a social worker.

Staff worked across health care disciplines and with other agencies when required to care for patients. Medical doctors and advanced nurse practitioners were in the ED regularly. Staff we spoke with informed us that speciality doctors were mostly responsive when asked to review patients they were contacted by the flow coordinator on duty and if there had been no response within the hour it was immediately escalated to the consultant. We observed a number of telephone discussions (and saw documented in medical notes) with speciality teams that facilitated patients being accepted for admission in order to reduce delays and facilitate timely care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service worked closely with ED staff and provided advice and support when required. Staff we spoke with also told us there was to be an increase in access to mental health support and a plan had been agreed to employ registered mental health nurses directly into the ED to provide further support and specialist care for patients without relying on agency staffing.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Staff could request support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week.

The frailty team reviewed all patients over the age of 75 and carried out risk assessments to improve on the patient's pathway. They were available Monday to Friday and the last referral time was 4pm. The staff we spoke with felt that if the service could be developed and extended there would be a greater reduction in hospital admissions.

Staff had access to X-ray and computer topography imaging 24 hours a day, 7 days per week and they were not concerned about any delays in reporting or accessing results.

The paediatric triage room was opened 24 hours a day and was covered by 3 paediatric nurses in the evening and 4 paediatric nurses during the day.

The discharge lounge was open 7 days a week. Social workers came into the emergency department and worked with the complex discharge team.

The service had a Same Day Emergency Care Unit which was opened 7 days a week from 7am to 9:30pm daily. This service relieved pressure on the ED.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the ED. Leaflets were available and given to patients for a range of conditions and we saw staff signposting patients to other helpful services during triage.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patients physical, psychological and social needs formed part of the ED admissions booklet. Patients were referred to their GP for continuing support if required.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patient records we reviewed had evidence of appropriate assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some ED nurses had recorded they had sought consent from a patient before carrying out an intervention.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff made sure patients consented to treatment based on all the information available.

Staff understood Gillick Competence and supported children who wished to make decisions about their treatment. Staff who worked in the children's ED department had a clear understanding of what Gillick competence meant. Gillick competence is a term used in medical law to decide whether a child (a person under 16 years of age) is able to consent to their own medical treatment, without the need for parental permission or knowledge.

Nursing staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). At the time of inspection, 87% of nursing staff had undertaken training in the Mental Capacity Act and DoLS.

Clinical staff received and kept up to date with training in the Mental Capacity Act 2005 and DoLS. At the time of inspection, 77.5% of clinical staff had undertaken training in the Mental Capacity Act and DoLs.

Managers monitored the use of DoLs and made sure staff knew how to complete them. Applications for DoLS were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed. We did not observe any patients who were subject to a deprivation of liberty during our inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and DoLs. Policies were in place to support staff to identify and take appropriate action when it was necessary to seek authorisation to deprive a patient of their liberty. The policy required staff to review a patient's mental capacity and identify the use of the least restrictive options in line with their legal duties. Staff had access to onsite safeguarding leads and an electronic system to raise DoLS applications with the local authority.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The ED monitored its use of chemical and physical restraint and provided an up-to-date policy and procedure for staff to refer to which included a process chart for ease of understanding.

Staff completed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms with patients and their families in line with national guidance. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency, for example cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both patient preferences and clinical judgement. The agreed clinical recommendations that are recorded include a recommendation on whether or not cardio pulmonary resuscitation should be attempted if the patient's heart and breathing stop. We saw ReSPECT forms had been completed in their entirety and staff had involved patients and their relatives in the process at the time of our inspection.

Staff supported patients to make advanced decisions about their care. The ReSPECT form was used in ED to record patient's wishes for their end of life care and included resuscitation decisions along with a preferred place of death.

Is the service caring?

Requires Improvement

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

Compassionate care

Staff treated patients with compassion and kindness. However, due to the demands and pressures of the department they did not always respect patients' privacy and dignity and take account of their individual needs.

Issues with the emergency department (ED) environment and patient flow meant patients did not always receive good, compassionate care. There was a lack of toilet and washing facilities for patients spending long periods of time in the department. Facilities for personal care were very limited, 3 patients who had stayed in the ambulance receiving area for over 24 hours had not been offered a chance to have a wash.

Staff did not always follow policy to keep patient care and treatment confidential. Staff maintained confidentiality as much as possible in the circumstances. However, it was difficult to maintain patient confidentiality when staff were discussing sensitive issues in the corridor, majors and the escalation area. Staff discussed potentially sensitive information which other people would be able to overhear.

Staff understood but did not always respect the personal and social needs of patients, and how they may relate to care needs. We spoke with a patient who said they needed the toilet and were brought screens so they could use a commode. They could safely walk but were not offered to be taken to a toilet which was their “much preferred” option. Another patient said they asked a doctor to show them where the toilet was and were ignored, they told us a short while later they had been incontinent of urine.

Staff were mostly discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The staff on the ED were not always compliant with National Institute for Health and Care Excellence QS15 (Patient experience in adult NHS services), as patients were not always introduced to all healthcare professionals involved in their care and were not always made aware of their roles and responsibilities. Patients were not always kept informed of staff changes. For example, a member of staff had been redeployed from another ward area to care for patients on the day of our inspection but had no interaction with a patient after being on shift for over 3 hours. They had been busy caring for other patients who required more support.

Staff mostly worked hard to protect the privacy and dignity of patients with use of curtains and screens. However, people could see through screens, so privacy and dignity was not always maintained. We observed a nurse taking bloods from a patient on a trolley in the corridor without the means to adequately protect their privacy and dignity. However, during the factual accuracy period, the Trust told us they had moved the escalation/overflow area to an internal space that was not used as a thoroughfare to improve the privacy and dignity of patients.

Patients said staff treated them well and with kindness. Most patients we spoke with told us that they were happy with their care and that staff treated them with kindness. They found staff to be hardworking and with the exception of the time it took to get a bed, they were grateful for the care they had received.

The feedback from the ED survey test was positive. Friends and Family Test (FFT) feedback was provided through completion of paper cards, through volunteer collection, and feedback provided via the trust website, and accessible through QR codes encouraging feedback on posters and patient discharge summaries. Of the FFTs completed, 97.7% of respondents rated their experience as very good and good (between April 2022 and March 2023), which was above the target, and comparable to 2021/22 (98%), 2020/2021 (97.2%) and 2019/2020 (97.1%).

There were a total of 711 responses from April 2022 to March 2023. Respondents said the nurses (99.8%) and doctors (99.5%) were kind; and a similarly high proportion were happy with the care they had received (99%).

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff were non-judgemental when caring for patients with acute mental health conditions.

Emotional support

Staff mostly provided emotional support to patients, families and carers to minimise their distress.

Staff did not always support patients who became distressed in an open environment and help them maintain their privacy and dignity. We observed a patient suffering from delirium who was attempting to climb out of their bed in the escalation area. Another patient on the corridor was confused and trying to come out of their bed. Staff had very minimal interaction with both patients who showed signs of confusion. A relative who had stayed with their relative for over 24 hours said staff were so busy and they stayed as they felt their loved one would not receive adequate care as staff always appeared busy. However, we observed 2 health care support workers holding an elderly patient's hand and providing compassionate care and support with their activities of daily living.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff providing emotional support and discussing patients' wellbeing in all areas of the department.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to explain patients care and treatment to them.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff said they had access to communication aids, and these were used to help explain care to patients who may have difficulties with expressing how they were feeling or who were living with dementia.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about the FFT and the hospitals complaints service was available in the department. The service had implemented a new SMS text alert system for responding to the FFT in October 2023.

The FFT response rate of 0.87% had significantly deteriorated in comparison to previous years, 2021/2022 (3%), 2020/2021 (12.87%) and 2019/2020 (4.87%). The trust shared an action plan with one of the objectives to improve on the FFT response rates across ED with an action to explore how the ED feedback can be used in the ED transformation work to support improvements. During 2020/2021 volunteers were introduced to support obtaining FFT responses following treatment in the ED, the reduction in volunteers continuing to support this activity had potentially contributed to the reduction in response rate. Following our inspection, the Trust introduced a text/SMS electronic feedback system, which saw the response rate increase to 4% in February 2024, which equated to 264 individual patient responses.

Staff supported patients to make informed decisions about their care. Doctors and nurses explained to patients and their relative's alternatives to treatments when these were available.

Urgent and emergency services

Is the service responsive?

Inadequate

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers tried to plan and organise services, so they met the needs of the local population but due to pressures in the wider health and social system the department, along with the wider hospital, was gridlocked. This meant facilities and premises were not always appropriate for the services being delivered. The service was consistently in escalation due to the capacity of the department. This was because patients could not always be transferred out of the department in a timely way. Subsequently patients were being looked after in parts of the department that were not always appropriate to meet their needs, such as the escalation areas.

Attendances to the emergency department (ED) was reported to be increasing week on week, with demand outstripping capacity daily.

Facilities were appropriate for the services being delivered. The ED had a room called ‘swan room’ which was used for patients requiring personal care and as a bereavement room. We observed a patient being moved from the corridor to the ‘swan room’ to receive personal care.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Child and adolescent mental health services were available between 9am and 1pm each day and was covered by 2 shifts that swap at 6pm with a crisis team available out of hours.

Patients over the age of 75 had a comprehensive geriatric assessment form within their notes. We saw evidence that their physical health, cognitive screening, falls, bone health and advance care planning management recommendation were carried out by advanced care practitioners.

Records showed patients had been referred appropriately and had been seen by supporting organisations. Dementia support staff worked in the trust and visited the ED daily to provide support and guidance to staff. The department also had staff champions within the team to support specialist care.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. There was a system in place to flag up patients living with dementia. There was a dementia

trolley that had twiddle muffs, shawls and easy-to-read communication sheets with key words. Staff used flags, such as blue butterflies' stickers to identify patients with delirium, dementia and learning disabilities. We spoke with 3 nurses who knew about the flag system and confirmed they had received dementia training. Nurses asked doctors to do a mental capacity assessment or a mini mental test if they were concerned about capacity.

Staff used picture sheets for patients with learning disabilities.

The emergency department was designed to meet the needs of patients living with dementia. The service had a dementia room with sensory lights which was used as a quieter area.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Specialist nurses and department champions supported ED staff to identify methods of assisting these patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available at reception for people who were hard of hearing, staff provided any additional support patients required.

The service had systems to help care for patients in need of additional support or specialist intervention. The frailty team attended the ED and screened every patient who was over 75. They carried out geriatric assessment on all patients over 75 and liaised with the medical team. We observed an advanced care practitioner who reviewed a patient and referred them for a CT scan and X-ray following a radiation therapy.

The children's waiting room was decorated with child friendly images on the walls. The area was quieter; and provided privacy from the main waiting area. A baby changing unit and toilet facilities were available to those using this area.

Staff used the 'SWAN room' for patients who required end of life care. Swan bags were available that contained leaflets and little hearts for patients and their families. The hearts travelled with the patients throughout their hospital journey and followed them to the mortuary after they had died.

The service had information leaflets available in languages spoken by the patients and local community. All printed information leaflets were in English, although staff had access to some online information in alternative languages which they could print for patients. Leaflets and signs in the department were in English which was in line with the local demographic.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This was primarily over the phone; staff reported that if they required alternative provisions such as a British Sign Language interpreter, this needed to be arranged. We saw that the department had a set of 'communication cards' which were developed by an external company for use by hospitals to communicate with patients. These cards had many images on; for example, a variety of body parts for patients to indicate where they felt pain, pictures of procedures to explain what might happen as part of treatment, as well as symbols for food and drink.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This was mainly sandwiches, plus toast and cereals at breakfast time. However, staff said they could access hot food on an individual basis if required.

Access and flow

Urgent and emergency services

People did not always have timely access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within 4 hours. There was a declining picture, consistent with increasing numbers of patients coming into the service. Patients were not discharged from the department or admitted to the ward in a timely way.

At our 2021 inspection, we were concerned that the service did not ensure patients could receive care in a timely way. We found this issue had not been resolved because of the continued level of demand on the service, and capacity within the wider health and social care system which had created a gridlocked hospital.

There were long-standing local and national issues with access and flow through the whole health and care pathway which resulted in 'gridlocked' or full hospitals. These included an increase in demand for services from an aging population living for longer with more conditions, insufficient capacity in adult social care continuing to contribute to delays in discharging medically fit people from hospital, and difficulty for some people getting care from a GP practice having a knock-on effect for emergency departments. From April to June 2023 the trust's ED occupancy was frequently over 250%, which led to delays within the department. Senior ED leaders demonstrated a good understanding of these issues and were working in collaboration with other divisions within the hospital and their system partners to try and improve flow within the wider hospital and the system generally. Patient flow coordinators had been recruited and were working to help identify opportunities to increase flow in the hospital and wider system to create capacity in the ED. Several initiatives had been introduced including virtual ward services which were well established within the local health economy. There were a number of pathways to support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. The team were continuing to work with external partners on initiatives to help some patients avoid admission to hospital when they could be treated at home, as part of a virtual ward, or by other community-based services.

Patients accessed emergency services when needed. However, they did not always receive treatment within agreed timeframes and national targets. Managers monitored waiting times.

Patient flow out of the department remained an issue. We reviewed a patient's notes who had been in the department for over 30 hours. We found they were admitted with a raised blood pressure and had been seen by a consultant who asked for a 24-hour tape (a device which measures a heart's activity) to be done either in hospital or by the GP. No action had been taken over 14 hours after this request had been made by a clinician.

The Royal College of Emergency Medicine recommends patients should wait no more than 1 hour from time of arrival to receiving treatment. From May to August 2023 the percentage of type 1 attendances treated within 60 minutes of arrival was consistently below the England average. The average percentage for the trust was 6% whereas the England average over the same period was 36%. During our 2021 inspection, we were concerned that the service did not ensure patients could receive care in a timely way.

Managers monitored waiting times. However, patients did not always receive treatment within agreed timeframes and national targets. The trust's percentage of patients admitted, transferred or discharged within 4 hours of arrival showed little variation over the most recent 12 months. The percentage was 47.4% in June 2022, and 46.4% in June 2023. The trust's percentage was lower (worse) than the England and Midlands averages. However, the percentage of type 1 attendances spending less than 4 hours in ED was below the England average for July and the start of August 2023. The average percentage for July was 43.8% and the latest daily figure on 9 August 2023 was 41.2%.

Urgent and emergency services

The percentage of ambulance handovers that took over 60 minutes for The Princess Royal Hospital had consistently been higher (worse) than the percentage for the regional ambulance service since September 2021. Recently the percentage had decreased (worsened) from 45.6% in December 2022 to 33.2% in August 2023, similar to Royal Shrewsbury Hospital. The percentage for the local ambulance service also decreased over the same period from 27.7% to 11.1%.

The average number of type 1 attendances from June 2022 to June 2023 was 10,289. Over the last 5 months, the number of type 1 attendances had increased from 8,767 in February 2023 to 10,875 in June 2023.

The trust's median time from arrival to initial assessment was consistently longer than the England average from May 2022 to February 2023. The trust's median time was the same as the England average for March and April 2023 but was longer than the England average in May 2023.

ED staff tried to facilitate care as quickly as possible for every patient. Flow coordinators helped to get patients moving through the department and identified any delays as early as possible. Delays in triage were not displayed so some patients were unaware of how long they could be waiting.

The ED had a flow coordinator responsible for the acute medical unit and a flow coordinator for the ED worked 7 days a week from 8.30am to 8.30pm. Flow coordinators liaised with social workers and community teams to get patients moving out of ED where possible and appropriate.

The trust consistently reported a longer median time from arrival to treatment compared to the England average from June 2021 to May 2023.

There was a considerable decrease from 2 hours 30 minutes in December 2022 to 1 hour 30 minutes in May 2023. Over the same period, the England average decreased at a slower rate from 1 hour 32 minutes to 1 hour 5 minutes.

From May 2022 to May 2023 there was a considerable increase in the trust's 95th percentile total time in the ED.

While there was a small decrease in the number of patients waiting over 12 hours from the decision to admit to admission from July 2022 (649) to June 2023 (525) the trust experienced highs of 1,090 patients during the winter. The average monthly number of patients from July 2022 to June 2023 was 714 and the average for July 2021 to June 2022 was 275. However, the Trust undertook harm reviews of patients waiting more than 12 hours from the decision to admit to learn from any themes and ensure no harm was sustained. These harm reviews showed no harm had occurred while patients were waiting.

The percentage of the trust's patients that left the ED before being seen for treatment was consistently higher than (worse) the England and regional averages from January 2022 to May 2023. From February 2023 to May 2023 the trust's percentage was between 7.1% and 7.4%, similar to February to May 2022. Over the same period, the England average was between 4.1% and 4.8% and the Midlands average was between 4.8% and 5.7%. From July to October 2023, 24% of patients reattended within 7 days after they had left without being seen. The trust had an action to undertake a review of the process for patients who left the department without being seen to identify areas for improvement.

Urgent and emergency services

During our inspection, the service was operating under severe pressure, and we saw patients had long waits to be seen. This included delays in ambulance handovers, access to triage, and review by a doctor. Capacity in the department was on the ED risk register. There were a number of mitigations in place to try to improve flow. The ED improvement programme had various workstreams which focussed on delivering continuous improvements in patient flow in a sustainable manner.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment.

Managers and staff worked to make sure they started discharge planning as early as possible. The frailty team attended the ED Monday to Friday to assist with discharges. There was a trust wide initiative to free up hospital beds earlier in the day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order free up hospital beds and obtain access to continuing care for patients who required this.

Staff supported patients when they were referred or transferred between services. Navigators and triage staff provided information to patients who were referred to other services.

The Trust's electronic recording system included the number of times the patient had attended the ED in the last 12 months on the front sheet of the patient's record. Care plans and management plans were in place for patients who attended the service on a frequent basis or had specific care needs, these management plans could be located on the patient's electronic record. Clinicians were alerted to their presence via a flag when the patient was booked in.

Managers monitored patient transfers and followed national standards. Surgical patients were transferred to other hospitals using recognised safety standards.

The median time to initial assessment has been decreasing since October 2022 and from March to April 2023 was the same as the England average.

The trust's percentage of patients waiting more than 4 hours from the decision to admit to admission has been decreasing since April 2022.

The trust's percentage of patients that reattended the A&E department within 7 days of a previous attendance was consistently lower than (better) the England and regional averages from June 2021 to May 2023.

There were no emergency readmission indicators flagged as a concern. The trust flagged as better than other trusts for emergency readmissions from January 2022 to December 2022 for acute myocardial infarction (57.9) and pneumonia (79.6).

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Information was available in the ED waiting areas on how to make a complaint. Complainants received a response from the ED within 20 days of making a complaint.

The service clearly displayed information about how to raise a concern in patient areas. There was signage in the department which advised patients on how to make a complaint or raise concerns if they needed to.

Staff understood the policy on complaints and knew how to handle them. Staff within the service understood the complaints procedure and were able to give advice to patients on the process if they wished to make a formal complaint to the trust.

Managers investigated complaints and identified themes. The service received 6 compliments from July to September 2023. According to data received from the trust, from April to September 2023 there were 106 formal complaints received by the service. The main themes identified were communication (39), clinical care/treatment (55) and staff attitude (33).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers. Complaints were discussed at clinical governance meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. They shared feedback from complaints with the individuals involved and the wider team.

Is the service well-led?

Requires Improvement

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

Leadership

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

The Emergency Centre was managed under the Medicine and Emergency Care (MUEC) Division. It had a triumvirate senior leadership structure which included a Divisional Medical Director, a Divisional Director of Nursing and a Divisional Director of Operations. The leadership structure in the Emergency Centre within the MUEC Division consisted of a Clinical Director, Centre Manager, and matrons. The nursing team were led by a matron who was supported by a team of band 7 nurses who took charge of the daily operational running of the service. The nursing team were led by a matron who was supported by a team of band 7 nurses who took charge of the daily operational running of the service.

The emergency department (ED) at The Princess Royal Hospital had an interim matron who joined the team 12 months ago. They had put a development plan in place for band 7s.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They were largely able to articulate the challenges within the department.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address these. During our inspection we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, leaders were aware the increase in attendances, flow issues and challenges around patients fit for discharge.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times and moving staff around the department to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate.

Staff told us they felt well supported by their senior team. They said they were visible and approachable, and the department worked well as a strong team. All those we met in the staff team said they felt confident and able to speak up to senior staff and managers. There was a learning culture in the department and effective support for staff to train and develop into more senior roles and learn new skills.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There were 7 strands to the strategy. These were excellence in patient care, leadership, team recognition, wellbeing, professional development, shared decision making and the workforce of the future.

The ED vision mirrored the trust-wide vision to provide the best possible care to patients. The strategy was focussed on improving flow and patient pathways to improve the patient experience.

The vision and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners The strategy involved working in partnership with integrated care system to get medically fit patients out of hospital as soon as safe to do so to improve flow within the wider hospital. Ultimately, this would mean patients would be able to access urgent and emergency care when they needed it.

Senior leaders recognised there was a direct corelation between the number of medically fit patients in the hospital who could not be discharged to an adult social care placement or to their own homes with a bespoke package of care with the number of patients waiting to access treatment whilst outside in an ambulance. The plan involved increasing community-based treatment to help avoid patients being admitted to hospital whenever possible and reducing the amount of time patients spent in hospital if they required an admission.

While the strategy was aligned to local plans in the wider health and social care economy, and services were being planned to meet the needs of the relevant population the strategy was still largely in the planning stages and was not fully operational at the time of our inspection. This meant at the time of our inspection there was not a strategy in place that could effectively reduce the amount of time patients spent in the back of an ambulance waiting to be handed over

to the ED, or the number of patients being nursed in the ED instead of on a ward, or provide poorly patients who needed a bed instead of having to sit in the fit to sit area while waiting for treatment. However, the Trust implemented improvement programmes which focused on flow, ambulance handover and de-escalation of emergency departments following our inspection.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. Staff felt supported, respected, valued and were positive and proud to work in the organisation.

Nursing staff told us they felt able to speak up when they had concerns and that managers listened to them and helped find ways to resolve problems. All of the staff we spoke to could tell us who the freedom to speak up guardian was.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively.

The trust was going through a large-scale program of transformation including a reconfiguration of urgent and emergency care services.

Staff felt the matron turnover was high because ED was too small for the number of patients they saw. They also raised concerns around plans to downgrade the department.

There was clear signposting for staff to submit feedback anonymously. As the results were anonymous it remained unclear if there had been any changes due to this system and results only shared with the “Time to talk” Team/ organisation. The service also had a dedicated app for staff to submit their ideas and receive feedback and next steps. Staff had submitted 45 ideas, for which they received a certificate when these had been implemented. Ideas were reviewed weekly at a dedicated meeting attended by a multidisciplinary team.

Governance

Leaders had implemented a governance structure for the service. However, we were not assured this was fully effective.

During our last inspection we raised a number of concerns about the care and treatment of patients. While we found some of the concerns raised had been resolved, the provider had failed to take effective action on several concerns. For example, patients were not consistently triaged within 15 minutes of arrival despite conditions imposed on the provider’s registration following our inspection in 2021. There was insufficient evidence found to support that senior leaders had a sufficient oversight and understanding of where the department was failing to meet standards in care. We saw staff failing to provide the required standard of care on multiple occasions.

There was a lack of effective delivery within the current governance structure for the management of certain performance matrix. At our 2021 inspection, we were concerned that the provider did not ensure there were governance processes in place which consistently assisted in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. However, senior leaders described effective structures, processes and systems of accountability to support the delivery of services.

Senior leaders explained that the executive board were well sighted on the challenges facing the ED and there were good lines of communication, that the board listened and were sympathetic and would take immediate action to support the department although they did not always have the means to provide a solution.

Senior leaders described a process of rapid review to learn from incidents and systems to ensure learning was disseminated to teams.

We requested for minutes of staff meeting but were told due to change in leadership within the department, meetings had not been minuted. The ED teams met regularly to discuss key agenda items, but staff did not capture meeting minutes.

Management of risk, issues and performance

Leaders and teams did not effectively use systems to manage performance. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. We were not assured systems were in place to support improvements.

We were not assured senior leaders had sufficient oversight of performance targets, there were significant issues especially around patient total time in the department, time to initial assessment and time from decision to admit. Senior leaders were aware of performance targets but whilst there were long-term plans to improve performance, we saw no immediate actions to address performance issues.

Staff held weekly monitoring meetings to monitor key performance. Following our inspection, the trust shared the key performance metrics report for July 2023. Despite improvement work, ED performance continued to be negatively impacted.

At our last inspection in 2021 we were concerned that the provider did not include all relevant risks within the ED were included and planned for in the service's risk register. However, we saw risk register entries reflected the issues staff told us were the biggest risks impacting the delivery of safe care and treatment. Although, these were risks that had been on the register for a long time, there were some actions completed and mitigated to bring about a change in risk levels.

The Shrewsbury and Telford Hospital NHS Trust urgent and emergency care (UEC) improvement programme 2023/2024 had an objective to deliver continuous improvements in patient flow in a sustainable manner. The ED transformation project was launched in October 2022 with a workstream focused on initial assessment (IA) and flow. There were various workstreams which included, therapies, discharge and flow, virtual ward direct access pathways, escalation, and Frailty. An ED senior matron led the IA task and finish group to allow focused work and leadership. Actions and trajectories continued to be monitored via the emergency transformation group and the workstream task and finish groups. We looked at minutes of the SaTH improvement group chaired by the interim deputy chief operating officer which revealed that workstreams were progressing at pace.

The service used evolving standard operating procedures (SOPs) to help manage risk. This meant that procedures could be changed to manage risk flexibility to take into consideration, for example, changes in demand or in staffing levels. Leaders told us they used an evolving SOP for the escalation corridor due to increased challenges with capacity in the ED. However, they were confident that the current SOP was comprehensive for managing safe patient care.

Senior leaders were sighted on the corporate and clinical risk register. They told us about risks being allocated, reviewed and with mitigation being in place.

Matrons reviewed performance and produced exception reports. We reviewed the exception report for July, August and September 2023. The top highlights for good compliance were missed medication doses at 94%, safety, privacy and dignity patient experience at 91% and falls at 85%. infection prevention and control (IPC) audit was at 85%. The results were shared via the ED communication page and staff meeting. The service had an IPC board and band 7 nurses carried out departmental walks.

The fire risk assessments for the EDs were under review with consideration that spaces that had been converted or adopted for patient use may have inappropriate surface finishes and fixtures for the spread of flames, which may impede access or egress in the event of an emergency. The fire risk assessment for portable oxygen equipment was also under review as it was identified they may increase the risk of fire due to problems with leakage.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The department was aware of its performance, resilience and risk from a local dashboard, called the whiteboard, designed to provide live data throughout the day and night. This was only visible to managers within the department, hospital leaders, and those whose role was specifically related to the management of flow.

Four times a day the nurse in charge completed a document to reflect the status of the escalation level of the department with data taken from the white board and from the ambulance service's dashboard. The nurse in charge then escalated any concerns regarding capacity to the emergency practitioner in charge, and hospital leaders so work could commence to reduce capacity. Information for patients in the waiting area about expected length of waits for treatment was also generated manually.

The trust had plans to improve patients notes which were a combination of paper and electronic notes. Senior leaders told us a new paper free patient notes system was due to be introduced in the ED in April 2024 as part of the trusts transformation process.

We observed computer screens being on inactive mode when not in use and staff swiped in an out in majors and resus areas.

The service collected reliable data and analysed it. Leaders within the service had access to national benchmarking data and staff had access to live data about timeliness of patient care.

The service had effective arrangements to ensure data or notifications were submitted to external bodies as required. During the inspection process, the trust sent data in a timely manner.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

At our last inspection in 2021 we were concerned that the provider did not ensure patients were consistently involved in the plans to improve ED services, so they reflect the needs of the local population. However, senior leaders were able to demonstrate patient representatives sit on a number of meetings aimed at improving patient care and have also been involved in designing questions for the patient satisfaction survey. Leaders explained that when patients or family members have made complaints, they have used the process to encourage them to join the team of patient representatives.

Leaders told us staff are engaged in designing SOPs for service delivery because of their specialist knowledge. The SOP would require sign off at management level to ensure risk sat at an appropriate level. Staff are invited to provide feedback including service improvement ideas through the staff survey, and through a bespoke app which can be easily accessed through a QR code.

Leaders also described some of the changes to the service that took place as a direct result of feedback from staff including making changes to the skill mix of staff in some ED areas.

The ED patient experience group had identified 3 key areas for focus which included communication, complaint management, and culture. The group sought to increase the number of patient representatives involved in the group and explored the involvement of ED volunteers to provide greater insight. A priority for the group was to support the acute floor pathway which opened in December 2022.

The hospital transformation programme (HTP) engagement sought to involve a diverse range of community members. Specialist groups were being developed with a specific focus on engaging with seldom heard groups, and bespoke sessions offered to a range of groups to engage them in the HTP work and ensure their voices were heard.

The trust appointed into a social inclusion facilitator role to address gaps in engagement with seldom heard groups.

A special day had been planned for ED Band 7 emergency nurse practitioners on behaviours and compassionate leadership. Other division led team away days had been scheduled which included a matron away day scheduled for November 2023.

A hot debrief model led by the psychology hub had been successfully introduced in ED. An event to publicise the ‘ImproveWell’ app was held, which had a positive impact on sign-up and ideas generated.

The trust scored worse than other trusts in section one of the CQC urgent and emergency care survey 2022 with the main concern being around waiting time. The Princess Royal Hospital had 2 questions that scored “worse” and 2 questions that scored “somewhat worse.” The trust scored “worse” than other trusts for 2 sections and “somewhat worse” for 2 sections:

- S1. Arrival: “somewhat worse”
- S2. Waiting times: “worse”

- S6. Environment and facilities: “somewhat worse”
- S9. Experience overall: “worse”

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff embarked on a getting to good improvement journey and worked with health and care partners on implementing a system-wide urgent and emergency care improvement programme. The aim of the programme was to ensure optimum flow into and out of hospitals so that patients are not facing long waits to access a hospital bed or long delays leaving the hospital when care is no longer required. Alongside some pre-hospital workstreams led by system partners, the trust had 8 workstreams which focussed on improving discharge, flow pathways and ward processes.

There were plans in place to develop a frailty assessment area within the ED to reduce the length of stay for the older population.

Leaders gave evidence of changes resulting from our last inspection, such as moving wash hand basins into easy reach and replacing flooring with non-porous vinyl.

Services for children and young people

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of children, young people, and staff.

The trust had a compliance target of 90% for staff training, this had been met in the following areas, conflict resolution, equality, diversity and human rights, fire safety awareness, health and safety and welfare, infection prevention and control - level 1, moving and handling - level 1 (load handling), preventing radicalisation - level 1 (BPAT) and level 3 (WRAP), domestic abuse awareness.

The service completed EPLS (European Paediatric Life Support) and ALS (Advance Life Support) the compliance for this was 96%. We witnessed a training session taking place on the ward during the inspection.

The compliance for information governance and data security awareness training was 86.64%.

Staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

The data showed that Oliver McGowan training completion rate was 76.06% which was below trust target of 90%, however, this was a training session for completion by the end of March 2023.

The data for learning disabilities training compliance were 96%.

For the staff on the neonatal unit completion of Mental Capacity Act and Deprivation of Liberty Safeguards training were 71.93%.

For the Staff on the children's ward and assessment unit completion of Mental Capacity Act and Deprivation of Liberty Safeguards training were 83.96%.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff told us that training was monitored by managers and if training became out of date, they would receive an email to remind them the training required completing and a completion date was also identified.

Services for children and young people

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

The data for August 2023 reflects that all staff within Ward 19, Ward 23 and assessment unit had completed children's safeguarding Level 3 were at 100% which was above trust target of 90%.

For the advanced neonatal nurse practitioner's compliance was at 75% which was below the trust target.

The data for August 2023 showed all Neonatal and medical staff were trained to their required level for safeguarding. These levels were all above the trusts target of 90%.

The data for August 2023 showed all staff except specialist nurses in the neonatal unit were at 100% for prevent training. Specialist nurse completion rate was 50% which was below the trusts target, of 90%.

The data for September 2023 showed all staff from the paediatric unit and medical staff had completed children's safeguarding Level 3 were at 100% which was above trust target of 90%.

The data for September 2023 for safeguarding adults training for paediatric unit reflects that medical staff and specialist nurses paediatric were at 86%, all other staff had 100% completion.

The service completed child sexual exploitation training; this was within safeguarding level 3 training for all staff.

The data for August 2023 showed all staff except medical staff were between 93% and 100% compliant with prevent training. Medical staff completion rate was 86% which was below the trusts target.

The trust admitted 16 to 18-year-olds on specific adult wards. The staff who worked on these wards had completed safeguarding children's level 3; this was currently at 88% which was just under the trusts 90% target.

Staff knew how to identify children and young people at risk of, or suffering, significant harm and worked with other agencies to protect them.

The service completed safeguarding risk assessments on all children and young people who came into the assessment unit, or onto the ward. If these identified any safeguarding concerns the staff would raise this with the safeguarding team and other agencies.

During the inspection there had been evidence of staff raising safeguarding concerns and identifying children or young people who were on child protection plans; these were all dealt with in line with the trust policy.

Managers told us all patients seen on the ward were checked against the Child Protection Information System (CPIS) and would seek support from the safeguarding lead to see if a referral had been completed.

The service identified and had a paediatrician consultant on rota to support the service if any safeguarding concerns were raised.

The service completed a monthly safeguarding children's activity report. The report summarised all Safeguarding Children team activities cross site including training compliance.

The service documented in patients records if the child or young person had been on a child protection plan or if a safeguarding had been raised previously. This ensured all staff had the knowledge and understanding of how to protect and safeguard children and young people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff had a good understanding of how to raise concerns in relation to safeguarding, and the staff had a good understanding of the various kinds of abuse.

Staff and the mangers had a good understanding of involving other agencies i.e., police, local authority, safeguarding leads.

Staff told us that if a child/young person disclosed they have been sexually active, staff had a good understanding of consent in relation to a child under 16 years of age who presented at the service.

Staff followed safe procedures for children visiting the ward.

Staff ensured all people/visitors who came to the service were asked who they were visiting, and no one could access the service without staff letting them in with a swipe card.

Staff let people leave the department by the swipe card, this was to ensure the doors remained locked. This also prevented unauthorised people accessing and leaving the wards/units, ensuring the safety of the children and young people and their families.

The service had an abduction policy and missing person policy in place, but they did not conduct practices of how you would deal with a situation if a child were to be taken from the ward. However, the service had a good understanding of who could and could not attend the wards/units due to safety of the patients, and no one could enter or leave the wards/units without a staff member opening the doors. Staff also knew how to follow the protocol if there was an attempted abduction of a child.

Cleanliness, infection control and hygiene

The service managed infection risks well. Staff used equipment and control measures to protect children, young people, their families, themselves, and others from infection. They kept equipment and the premises visibly clean.

We saw areas were visibly clean and had suitable furnishing which were clean and well maintained.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

The service employed both housekeepers and domestic staff, who covered the day-to-day cleaning and the deep cleans within the wards and units.

Staff completed cleaning records daily. These records identified what was cleaned daily, weekly, and monthly. However, there were some gaps on the records which indicated that some cleaning may not have taken place.

The service complete infection prevention and control quality ward assurance audits, which identified overall compliance with infection prevention and control measures. Where there were things that need to be addressed, an action plan was completed.

The service regularly completed Quality Ward Walks. These were completed 3 monthly and had a target for compliance of above 90%. If compliance were below 90%, the infection prevention control (IPC) team would visit more frequently.

For 3 months June, July, and September 2023 within the Neonatal unit, compliance ranged between 80% and 93%.

For the children's ward this had been completed on 11 July 2023 and had achieved 73%. However, the audit was completed again on 19 July 2023 and improvements had been made and scored 97%. The service had policies and procedures in place in relation to IPC.

Curtains and blinds were cleaned regularly and were identified within deep cleans.

Staff followed infection control principles including the use of personal protective equipment.

The service had hand sanitizer attached to the walls, which was situated around the wards and units. This was for both staff and visitors to use.

During the inspection we witnessed staff washing their hands or using hand sanitizer, this also took place between seeing patients. Staff also used gloves and aprons when required.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff ensured that once equipment had been used, for example cots and scales, these were cleaned after every use.

Once a bed space became empty the staff ensured that a thorough clean was done and "I am clean" stickers were placed on equipment.

Hazardous cleaning equipment were stored correctly.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Children, young people, and their families could reach call bells and staff responded quickly when called. On the first day of inspection, we were told the call bells were faulty, and estates were aware, these were fixed whilst we were still on site. The call bells were only faulty for a short period of time and the staff ensured patients were aware and had no impact on patients' safety.

Parents told us staff responded to call bells in a timely manner.

The design of the environment followed national guidance.

Services for children and young people

The service ensured the ward, assessment unit and Neonatal all had secure entrances where visitors needed a staff member to allow access. The ward and assessment unit had ward clerks and they were able to direct visitors to the correct areas and access the areas with a swipe card.

The wards and units also had intercoms with a camera to be able to identify anyone who wanted to enter the departments.

The ward had 3 separate garden areas which were secure. Access to the gardens was through the ward.

All corridors and fire exits were kept clear and clutter free.

Patients who required closely monitoring due to their illness/condition were placed near the nurse's desk without being intrusive to the child or young person.

Staff carried out daily safety checks of specialist equipment.

The service recorded all equipment that needed to be repaired and was taken out of service until the equipment had been replaced or fixed.

The service completed a yearly electrical safety test, which identified that all equipment were safe to be used, the service also kept records to show the equipment had passed.

The service had suitable facilities to meet the needs of children and young people's families.

The service had suitable equipment for children and young people and to support children and young people with additional needs for example, hoists, changing beds and bath.

A paediatric resuscitation trolley was available in all three areas. These were secured with a tag and checked.

The sepsis trolley within Neonatal was also secured and checked. However, there were 3 dates on 1, 4 and 9 October 2023 where the trolley had not been checked.

The service had a milk fridge which was situated in a locked room and the fridge was kept locked. The service monitored and recorded fridge temperatures for the fridge located on the ward. However, these had been higher than 8 degrees Celsius which was the maximum temperature. These concerns were raised with staff at the time, and we were informed that the seal had broken. The observations machines were outdated, when discussed with the service they informed us, they were waiting for new machines to arrive.

The service had enough suitable equipment to help them to safely care for children and young people.

Staff told us observation machines did not always work correctly; however, new ones were on order to replace these current machines, staff also told us that there had not been any impact on the deterioration of children or young people as there is an escalation policy in place in regard to observational equipment concerns which outlines the alternative equipment available and agreed escalation processes to more senior staff.

We noted all sharp bins were signed, dated, and stored correctly.

The service had a personal emergency evacuation plan in place and located at the nurse's desk.

Staff disposed of clinical waste safely and in accordance with correct separation.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately.

The staff use Paediatric Early Warning Score (PEWS) system when monitoring patients' vital signs and deteriorating patients.

The ward used an electronic board which identified where all the children and young people were situated. This also identified the patient acuity.

The service used Paediatric Deteriorating Patient Sticker, which were either red, yellow, or green. These were placed on each child and young person's files to make it clear of the level of deterioration the child or young person was at and what action had been taken or what next steps were to be followed.

The data received from the trust stated for July, and September 2023 that PEWS had been completed and were all reported at 100%, However, for August 2023 relating to blood pressure recorded 4 hourly or rationale documented were reported at 80%.

The service had a sepsis management and audit process in its children and young people standard operating procedure. This was in date and when it was next to be reviewed was stated.

The medical staff on the children's ward completed training for sepsis the compliance rates were 66.67%, which was below the trust target of 90%.

The medical staff on the Neonatal unit completed training for sepsis the compliance rates were 100%.

The nursing staff completed training for sepsis, the overall compliance rates were 84.62%, nursing staff in Neonatal for sepsis training were 38.46%.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The service undertake risk assessments on admission and daily. For CYP with Mental health needs, these are completed every 12 hours, together with an environmental risk assessment on admission and then every 12 hours thereafter.

The risk assessment had a patient safety checklist and if anything needed to be removed from the bed space the young person was staying in, and the rationale of removing items. For example, oxygen tubing, as this could pose as a ligature risk.

The risk assessment had a section of patient's appearance and description, in case the young person attempts or absconds from the ward.

The service had a Standard Operating Procedure for Sepsis Management and Audit Process in Children and Young People, which was in date from July 2023 and the review date was September 2026.

A mental health nurse was available Monday to Friday between 9am and 5pm. The mental health liaison team provided support out of hours. The service also had access to Child and Adolescent Mental Health Services (CAMHS) service located outside of the trust and could support a child or young person to complete a referral within 4 hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide.

At our 2021 inspection, we were concerned how the service supported children and young people's mental health concerns. During this inspection, we identified the improvements the ward had completed, this included, implementing an eating disorder care bundle which was person centred to each individual young person.

The service had also improved by introducing a mental health risk assessment, which covered all aspects of risk and safety. This had contacts within the trust and within the local area of the people or other agency's they could call on for support, these included CAMHS, safeguarding team, doctors, social workers, police.

The risk assessment identified background, observations and behaviours, suicide risks and a summary of levels of risk and suggested actions.

There was a check list of who needed to be contacted and when this had been completed, in the situation of a child/young person were to leave the ward.

The service gained consent if the patient required a search of their belongings or of their person. Staff ensured the patient/parent signed the consent, and this had been completed with the observation of 2 staff members who would also sign the consent form.

At our 2021 inspection, we were concerned that the provider did not have knowledge of all 16 to 18 years old young people who were based in adult wards across the site. During this inspection, the service were able to provide a daily list which identified where the young people were admitted. The trust had also identified since the last inspection which wards young people were able to stay on. Staff on these wards receive level 3 safeguarding children training and additional support from the safeguarding team.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others.

Before children and young people, were discharged from the ward, the crisis team carried out a risk assessment, and the wards/units used a document called" ready steady go." All patients and transitions were discussed during liaison meetings with the crisis team. Home leave could be agreed prior to discharge, and this was discussed with the patient, parents, ward, crisis team to ensure the move back home went well.

For children and young people with complex mental health needs, a multi-disciplinary team (MDT) meeting with all care providers and the young person and family takes place.

Shift changes and handovers included all necessary key information to keep children and young people safe.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe.

The service had staff vacancies, which were reducing in numbers. Bank and agency staff were used to fill gaps. During the inspection, the shifts for both days and nights were covered and safe.

Vacancies on the children's ward had reduced from 20 in July 2022 to 11 vacancies in September 2023.

Vacancies on the neonatal unit had reduced from 7 in July 2023 to 5 vacancies in September 2023.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift, in accordance with national guidance.

Managers had a good understanding of what vacancies they had and how they were recruiting. Managers told us they have had some new staff join the wards/units, these staff were still supernumerary which meant they were not yet included in the numbers and required agency or bank staff to cover this.

The service followed British Association of Perinatal Medicine framework; this identified the number of nurses required as staff ratio to the needs of the newborn children on the neonatal unit.

The service had a target of having 70% for Qualified in Speciality (QIS) trained staffing and the service currently had 55% trained staff which was under the target.

The neonatal service have a target of 70% Qualified in Specialty (QIS) trained staff, as per the British Association of Perinatal Medicine guidelines. The service currently has 55% of trained staff which is under target. The service told us post inspection that their trajectory to achieve 70% is on schedule to be achieved by September 2025.

The ward manager could adjust staffing levels daily according to the needs of children and young people.

Ward managers told us they monitored the staffing levels daily and if they required additional staff for example, if a child or young person required 1-1 support, then staff would be brought in to support the patient.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low turnover rates. Within the Neonatal Ward 23 there were 9.9% of staff turnover between April and September 2023.

Within the Childrens ward there were 5.7% of staff turnover between April and September 2023.

The service had an increase in sickness rates.

Within Ward 19 children's ward the service had an increase in staff sickness this had been 3.12% in April 2023 and 3.84% in September 2023, however these were still overall low rates.

Within the Neonatal Ward 23 there was an increase since April 2023 to September 2023 of staff sickness this had risen from 7.17% to 11.73%.

The service had low and/or reducing rates of bank and agency nurses.

The children's ward had a reduced rate of agency staffing, in July 2023 which were at 6 and in September 2023 were at 5.

The Neonatal ward had a slight increase in agency usage in July 2023 being 2.0 and in September being 2.9.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

The service monitored the use of bank and agency staff and the service ensured where possible that when requesting agency staff, they were familiar to the services.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service ensured bank and agency staff completed an induction and ensured they kept using the same staff, so they had a good understanding of the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe.

The service had staff vacancies and the service used bank staff and agency staff. During the inspection, the shifts for both days and nights were covered and safe.

The service had low vacancy rates for medical staff.

In the Neonatal ward there had been a reduction in vacancy rates from 7 in July 2023 to 3 in September 2023.

For the children's ward there had been an increase in vacancy rates from 2 in July 2023 to 6 in September 2023.

The service had low turnover rates for medical staff.

The service had not had any turnover of staff since April 2023, which was recorded as 4.2%.

Sickness rates for medical staff were low.

For Neonatal medical staff turnover and sickness rates were very low.

For the children's ward medical staff turnover and sickness rates were very low.

Managers could access locum support when there were short falls in consultant cover, and the service ensured that locums completed a full induction of the wards and units.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had consultants, registrars, and senior house officer working across the children and young people's services.

The service had a consultant on call system to cover evening and weekends for the assessment unit and children's wards.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were comprehensive and held the correct information. Records were in paper form and had the relevant documentation in depending on why the child or young person had been admitted, for example: care plans, consents, sepsis assessments, safeguarding risk assessments.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

It had been evidenced on the patients records that a paediatrics ambulance handover form had been completed, which was passed to the nursing staff which highlighted why the child had been brought into the department.

The service documented in patients records when they have identified and actioned multiagency meetings due to the young person who were waiting for an autism assessment, and with the view of been discharged.

All records were stored securely within a trolley which were located around the ward. Staff ensured trolleys were locked to prevent unauthorised access.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

All medicines were stored in a locked medicines room and controlled drugs (CD) were stored within a locked cupboard within a locked room.

CDs are medicines which required more control due to their potential for abuse) were stored correctly and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff. All unused CDs were taken away by pharmacy.

The pharmacy carried out regular checks of medicines, updating stock, removing unwanted medicines s, and destroying unwanted and out of date medicines.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their carers about their medicines.

During the inspection we witnessed staff administering medicines and explaining to the child/young person and their parents/carers of what they were doing and what medicines they were giving, this was recorded within the patient records.

Staff completed medicines records accurately and kept them up to date.

During the inspection 11 sets of patient’s records were reviewed, medicines had been recorded and monitored.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

The pharmacy team had a good oversight of the medicines within the service and records were up to date and then enabled the correct information to be passed on when the child or young person moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service shared information relating to safety alerts memos via an email. These identified when this took place and what the action was. Staff had a good understanding of safety alerts.

The service ensured people’s behaviour were not controlled by excessive and inappropriate use of medicines.

During the 2021 inspection, there were concerns relating to the administration of rapid tranquilisation not being completed correctly. During this inspection, the administration of rapid tranquilisation had been completed correctly, there had only been 1 occasion where this had been administered to a young person in the last 6 months, which was in line with the trusts policy.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy.

Staff informed us that when reporting incidents that these were logged on Datix system, these would then be reviewed by senior staff. Staff had a good understanding of the incident policy and their responsibilities.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation if and when things went wrong.

The service had a duty of candour policy, and the staff understood the importance of this.

Staff received feedback from the investigation of incidents. and looked at improvements to children and young people's care.

Staff told us they received feedback via emails and within the team meeting of any learning that had been identified from incidents.

Staff told us they felt they could approach managers if they wanted to discuss any concerns or incidents that had taken place.

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations.

Managers completed a serious incident form when something had happened, this would identify the background of what happened and information relating to the patient and what learning could be completed to mitigate this from occurring again. Once this had been investigated the service completed a final report again outlining the patient background, what happened, what did they find during the investigation and any learning and action plans. These were also discussed with the family of the patient.

Managers took action in response to patient safety alerts within the deadline and monitored changes.

Managers monitored patient safety alerts, and escalated the concerns to the staff and ensured theses were action and where necessary the equipment removed from use.

Is the service effective?

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Managers reviewed and updated policies and these were discussed within governance meetings.

Post inspection we reviewed 13 policies in relation to children and young people's service, they were all in date except for 3, and the trust had informed us these were under review.

Staff could access policies, procedures, and guidance, they were located on the trust intranet.

Services for children and young people

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice.

During the last inspection, the service had conditions placed on them in relation to not admitting anyone into the wards/units under the age of 18 who had isolated acute mental health needs. During this inspection we found this condition had been complied with.

The service work closely with Child and Adolescent Mental Health Services to ensure children and young people who present to the ward with a medical need and a mental health issue received the care and support that was required. The service also had the support of a mental health nurse, which had been put into place since the last inspection and they support both children and young people and the staff.

During handover, the children/ young people who were on the ward that required additional psychological and emotional support were discussed. Staff worked closely with the child/ young person and their families. An example: there had been concerns relating to a young person gaining support relating to their mental health in the community, and the team organised a multiagency meeting and including the community support to put a plan in place for the young person to return home and ensuring the correct support was arranged.

Nutrition and hydration

Staff gave children, young people, and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people, and their families' religious, cultural, and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

During the inspection we witnessed breakfast and lunch rounds and spoke with children and young people and families/ carers. Choices were given of what they would like to eat and drink.

Staff told us children/young people who were on the eating disorder care bundle had identified meal plans depending on how many calories need to be taken during the day.

Staff told us they offered a range of food for patients and families who required culturally specific diets.

The service offered food and drink to parents/carers. There was a parent’s room where they were able to make hot or cold drinks, and a fridge for them to put any food in which they brought into the ward.

The families/carers could also access a café that was situated just outside the department which provided hot and cold food and hot or cold drinks.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed.

Whilst reviewing the children/ young people's records, the records we reviewed identified fluid balance charts were completed accurately. Also, within the eating disorder care bundle there were records of diet charts, which monitored what food had been offered, what food had been eaten or refused, how much fluids had been taken and how many calories had been taken.

Services for children and young people

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

The service monitored fluid and food input and monitored and weighed nappies, to monitor the output of urine and bowel movements. This had been documented in the patient records, this was also documents on the diet chart within the care bundle document.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it.

The ward had access to a dietitian to support with meal plans and they were included in multiagency meetings for the children/young people. This was also documented within the patient records.

The service had access to a speech and language therapist, occupational therapist, to support the children and young people when required.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff were trained and were able to recognise and monitor children and young people's pain.

Within the 11 sets of patient's records reviewed during the inspection, pain score had been monitored, and pain relief had been administered if required.

Children and young people received pain relief soon after requesting it.

Parents and cares told us when they have requested pain relief the child or young person received this in a timely manner. All pain relief had been prescribed, administered, and recorded correctly.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits.

The service complete National Neonatal Audit Programme which reported on aspects of care given to babies on neonatal units. These below figures were from the 2022 report.

For example: out of 62 mothers with a recorded outcome, 58.1% were given a full course of antenatal steroids; these were above the national average, where 52.0%.

There were 69 babies with a recorded outcome, 75% had their cord clamped at or after one minute (deferred cord clamping). These were above the overall proportion, where 60.4% of eligible babies had deferred cord clamping.

There were 30 babies born at less than 32 weeks of which the babies with a recorded outcome, 83.3% had their first measured temperature of 36.5 to 37.5°C within one hour of birth. These were above the national average.

The first consultation following admission occurred within 24 hours for 96.6% of the eligible episodes with a recorded outcome. These were above the national average, where 95.9%.

The service follows Paediatric Diabetic Ketoacidosis guidelines for the management of children and young people under 18 years of age.

The service completed audits for PEWS and pain scores on ward 19 which followed local protocols.

In relation to PEWS on ward 19 for August 2023 the score was 97.3% and for September 2023 the score was 100%

In relation to pain scores on ward 19 for August the score was 100% and for September 2023 this was also 100%

On ward 19 they completed fluid balance audits, for July 2023 these were 98.3%, for August 2023 these were 92% and for September 2023 these were 91.7%.

On ward 19 they completed food nutrition audits, for July 2023 these were 73.9% for August 2023 they were 90.9% and for September 2023 they were 46.7%.

Any actions from the results which were red were discussed within Governance and a plan for spot checks were completed by ward managers.

Fluid balance and management was taught within the new starters programme to set required standards. Fluid charts were reviewed to highlight the importance of fluid balance review every 6 hours.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The trust informed us there had not been any audits completed in the last three months within neonates in relation to sepsis and deteriorating patients. However, the service did partake in audits relating to Neonatal Infection Guidelines to demonstrate compliance. This may mean the unit was not monitoring the outcomes for all newborn babies and could not always demonstrate the effectiveness of care and treatment. Performance against a number of key quality metrics was monitored via local audits.

Managers did not always use information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The Neonatal unit had no completed audits for the last 3 months. However, other areas within the service did complete audits and used them to improve care and treatment for children and young people. An example of this was missed appointments and how the service managed these to ensure that children and young people attended their appointments.

Managers of the children’s ward shared the audits with the team, and they work together to ensure the best care for the children and young people which resulted in improving care and treatment for the people that use the ward.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance, although compliance rates did not meet trust target, and held supervision meetings with them to provide support and development.

The clinical educators supported the learning and development needs of staff.

The service ensured all junior doctors had a clinical supervisor and education supervisor, and they worked with the junior doctors to go through portfolios of learning and training and provided ongoing mentoring.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of children, young people, and their families.

The ward had support of a mental health nurse, who worked directly on the ward and offered support and training to staff. This included eating disorders in practice and looking at case studies.

The service did not have a learning disability nurse; however, the mental health nurse supported children and young people where required.

The ward employed a teacher who worked term times. The ward also employed youth workers and Play specialist.

Managers gave all new staff a full induction tailored to their role before they started work.

All staff received a full induction which were tailored to meet the needs of the children and young people who attended the ward, neonates, and the assessment unit. This included a tour of the ward, and assessment unit, arranging ID badges, completing hand hygiene assessment, completing an induction checklist, and competencies, and meeting other staff, for example, play therapists, diabetic nurse specialists. Also, staff are given a 6-week supernumerary period to allow training to be undertaken and to complete the area specific competency document. Informal documented progress meetings are also undertaken with the PEF and Ward Manager and supernumerary status is extended accordingly.

Managers supported staff to develop through yearly, constructive appraisals of their work.

The service which includes the paediatrics service appraisal rates were 84.17%.

For the Neonatal unit the overall appraisal rates were 66.67%.

The service completed safeguarding supervision monthly and this was held over an online meeting.

Managers supported staff to develop through regular, constructive clinical supervision of their work.

The service stated generic clinical supervision was informal using the listen, action and improve sessions and attendance was not recorded. However, staff told us they felt supported and could discuss anything that was on their minds.

Services for children and young people

The trust stated the Professional Nurse Advocates (PNA) Lead had provided 1:1 support for a small number of colleagues within the Neonatal unit. There were plans to provide group Restorative Clinical Supervision (RCS) sessions for staff within the Neonatal unit. PNA support was available from the Deputy Director of Nursing, the Maternity service Professional Midwifery Advocates (PMAs) and the Neonatal Service were awaiting the commencement of a nurse who is a PNA.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff told us training was identified, and they complete their mandatory training online. Staff were given time outside their shifts to be able to complete training. The service also completed face to face training on selected training sessions.

Staff told us managers were very supportive and approachable and would encourage staff to develop their own skills and knowledge.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit children, young people, and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care.

The service completed hand overs during the day this was where the team came together. These were a detailed review of all children and young people, which included, medicines reviews, hydration, eating plans for young people currently in the emergency department, family involvement, diagnosis and treatment plan updates, surgical patients, and feedback from the surgical team.

During the handovers staff discussed incident forms which needed to be completed and identified staff to attend ward rounds with the consultants to ensure they facilitate continuous care. The team discussed which clinician would support the follow up of children and young people in the emergency department, consultations with Neonatal and monitoring admission onto the ward.

All staff required from other teams joined the service in multiagency meetings and they were involved in assessing, planning, and delivering care and treatment.

Staff worked across health care disciplines and with other agencies when required to care for children, young people, and their families.

Staff ensured they worked closely with other teams within the trust including transitions service, community teams, social workers, and external agencies including the police.

The service ensured the children/young people received consistent care, this was person-centred, and families were supported when moving between service.

The service worked closely with the transition team to ensure that transitions were completed correctly and in the best interest of the child or young person, the team also liaised with the family/carers to help them understand the next steps of the person's care.

Services for children and young people

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

The service had a good understanding of children and young people's mental health need's, the service worked closely with community services and the local CAMHS. For example, a young person in the ward required support in the community to enable them to return home, a multi-agency meeting was arranged, which included the young person, parents, CAMHS, dietitian, consultant, mental health nurse and lead nurse.

Seven – day service

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway.

The consultants led daily ward rounds including the weekend supported by the nursing staff.

The service had consultant on call cover Monday to Friday, Saturday, and Sunday 9am to 3pm and then after an on-call consultant based off site.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The service could access support from the community team and the mental health team 24 hours a day, children and young people also had support from a mental health nurse Monday to Friday 9am to 5pm.

The service did not have a learning disablity nurse employed; however, the Youth Worker is experienced in children and young people with autism and the mental health nurse supported when staff required. The service could also seek support from the safeguarding team if required.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had information relating to promoting healthy lifestyles this included healthy eating, sexual health, how to deal with difficult days, supporting your mental health, and a poster stating "you have rights" which explains their individual rights.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We witnessed staff talking with children and young people in relation to making positive choices relating to healthy lifestyle.

The service used an eating disorder bundle which supports children and young people, this included a page which identifies the individual needs and likes, dislikes, what makes them happy and what may cause anxiety.

Services for children and young people

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Staff had a good understanding of supporting children and young people with mental health needs, we witnessed staff speaking with patients, and gaining their thoughts about their care and treatment.

The service spent time with children and young people to make coping tool kits, these were boxes that the young person would make. They could place anything thing in there to help them deal with any stress or anxieties they may have, and that would help them cope with situations they may feel overwhelmed or be struggled with.

The service completed a mental health assessment risk and safety checklist for paediatric children under 18 years of age, these were completed within an hour of admission.

The first page of the booklet was gaining information about the child/young person, looking at background/ observations and behaviours.

There was a part relating to suicide risk screening, and why they may feel this, whether drugs or alcohol had been used and if family members were concerned, also if there had been any previous support or treatment relating to the young person's mental health.

The suicide risk screening then identified the level of risk and actions to be taken on accordance to the level of risk identified.

Staff made sure children, young people and their families consented to treatment based on all the information available.

The service ensured all 16 to18-year-olds who were placed in an adult ward were asked if they would like to be on the adult ward or on the children’s wards.

Staff told us and explained why gaining consent and involving young people in the decision making of their care and treatment they were receiving was important. For all children up to the age of 16 years old, consent had been sought from parents/cares and in line with legislation and guidance. For all young people 16 to18 years old were involved in the consent and their care and treatment.

Staff clearly recorded consent in the children and young people's records.

Whilst reviewing the patient records it had been evident that consent had been sought from the young people and parents/carers.

Staff understood Gillick Competence and Fraser Guidelines to support children and young people who wanted to make decisions about their treatment. Staff we spoke with understood how children were able to make their own decisions and in what circumstances.

Services for children and young people

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff on the Neonatal ward and unit were 71.93% compliant with Mental Capacity Act and Deprivation of Liberty Safeguards training.

Staff on the children's ward and assessment unit were 83.96% compliance with Mental Capacity Act and Deprivation of Liberty Safeguards training.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

At the last inspection there were concerns relating to children and young people with mental health concerns. Since this the service had implemented lots of changes, this included employing a mental health nurse, implementing the eating disorder care bundle and the mental health risk and safety check list.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people, and their families. Staff took time to interact with children, young people, and their families in a respectful and considerate way.

Staff were responsive when caring for children and young people, when they required the care and treatment, and personal care staff ensured this had been received and when required. For example: a parent and his son told us "That nurses were very kind and would help me when I needed it, he also told us that the nurse came to do my checks in the night, and I did not even wake up."

Staff spent time with patients and families and explained the care and treatment and what happened next, and they gave the children/young people or families time to ask questions. Staff checked they were ok before leaving them.

Staff told us when they had to have difficult conversations, they would use a separate room which was away from the bays, so this could be confidential and ensure the child/young person and their families had the time they required.

Children, young people, and their families said staff treated them well and with kindness.

When speaking with children/ young people and families they told us staff were very kind, and they felt well cared for.

The service displayed thank you cards outside the playroom and the theme of these were kindness and how staff made visits to the ward a positive experience for children, young people and their families or carers.

Services for children and young people

The service employed Play specialist and youth workers on the children's ward, they could also provide support in other areas of the service. We witnessed interactions between them and the child/ young person and saw the interactions were positive, kind, and individual needs were met.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.

When speaking with staff they demonstrated a good understanding and a non-judgment approach to supporting young people with mental health.

We witnessed that staff had a good understanding of the young people's behaviours, these were clearly documented, and the staff were consistent in their approach.

Staff understood and respected the personal, cultural, social, and religious needs of children, young people, and their families and how they may relate to care needs.

The service could access the chaplaincy if the children/young people and families requested this.

Staff shared examples of how they supported children and young people with diverse needs, for example: in relation to identity staff were aware of the needs of young people who were members of the transgender community and were sensitive to their needs.

Emotional support

Staff provided emotional support to children, young people, and their families to minimise their distress. They understood children and young people's personal, cultural, and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it.

The service had regular visits from Lottie the therapy dog. Lottie attended the ward, and the children and young people were excited to see her and spend time with Lottie. We heard about how Lottie's visits contributed positively to the emotional support of patients. Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity.

The service employed Play specialist and youth workers to help and support children and young people who became distressed. They had a good understanding of behaviour and had a good understanding of distraction techniques.

The staff were trained in specific neurological conditions such as autism awareness. Staff would use different forms of communication aids to help communicate with a child or young person who became upset or distressed.

The service had curtains around bed spaces to ensure privacy and dignity was maintained. The service ensured the garden areas were enclosed with high fences to prevent other areas of the hospital looking into the garden areas.

A young child explained to us how they did not feel comfortable taking their top off in front of others, and at times the staff needed to check their chest. They said, "they were very kind and encouraged me to be brave" to which they then stated the "the doctor was ace."

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Services for children and young people

The trust stated that all medical staff completed breaking bad news as part of their training, there were 3 consultants and 2 nurse specialists who had undertaken advanced communication skills training which included breaking bad news.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing.

During the inspection we witnessed staff showing empathy, compassion and kindness to the children, young people, and their families.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people, and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Children and young people and their families told us they had been kept informed of the care and treatment they had received. We were told staff explained this in a way the children and young people and families could understand, and that families were also able to ask question in relation to the care and treatment.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary.

The service had access to Picture Exchange Communication Systems for all nonverbal children/ young people to be able to express feelings/ wants/needs. These were easily accessible in the playroom.

The Play specialist stated that they had basic knowledge of Makaton, which was a form of sign language, which they would be able to use if required.

Children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this.

The service received feedback from children/ young people and families.

Feedback for Neonatal consistently achieved 100% positive feedback between July and September 2023.

For wards 19 and 20 received high levels of positive feedback (between 95 and 98%) between July and September 2023.

Staff supported children, young people, and their families to make decisions about their care.

Children and young people and families told us they were involved in making decisions in relation to their care, this had also been evidenced within their records.

Patients gave positive feedback about the service.

Children and young people and families told us:

Services for children and young people

A parent told us that due to their child not sleeping very well, and them feeling tired, the staff offered to make a bed in the quiet room so the parent could still be close if her son needed her due to having autism, which she declined and went home as she felt happy, and that her son would be safe.

“Huge thank you to all the staff on the Children’s ward (19) for the support you gave me and my daughter, whilst she was admitted having an MRI (Magnetic Resonance Imaging) of her hip. Your kindness and generosity towards her has not gone unnoticed. She has told everyone how amazing you were.”

“My husband, and I would just like to say a massive thank you to everyone on Children’s Assessment Unit and the Children’s ward for the outstanding level of care we received during our daughter’s recent 3-night stay. Every person we encountered was kind, compassionate and made an extremely traumatising experience a little bit more bearable. No stone was left unturned in the attempt to find out what was wrong with her, and we appreciate all efforts made.”

One child did explain to us that they did not feel comfortable taking their top off in front of others, and at times the staff needed to check their chest, and they said, “they were very kind and encouraged me to be brave” to which they then stated the “the doctor was ace.”

During the inspection we heard positive feedback from parents and children, with examples of their experiences of the ward and staff.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the changing needs of the local population.

Managers planned and organised the services in relation to admissions, support for the assessment unit when it became very busy, which the managers could identify when theses time were.

The service worked with the local mental health service, and the Children and Young People’s Mental Health Crisis Team to ensure that the staff team could receive support when a child or young person were in crisis; this included out of hours, and they could attend to complete assessments within a 1 and 4-hours’ time frame.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Staff had a good understanding of mixed sex accommodation. There had been no mixed sex breaches in the last 12 months.

Facilities and premises were appropriate for the services being delivered.

The service had suitable facilities/equipment and premises to meet the needs of all children and young people who were using the service. This included specialist equipment including hoists and changing beds for showering.

The service had a play area and garden and an adolescence room and garden, so children could interact with other children and young people and be able to move away from their bed space. The outdoor play area had equipment to enable children to be active and enjoy being outside.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.

Since the last inspection when concerns were raised in relation to children and young people's mental health, the service had employed a paediatric mental health nurse and a youth worker who worked 9am to 5pm weekdays. The service also had access to out of hours CAMHS nurses to support the children and young people ensuring that they could receive support 24 hours a day 7 days a week if needed.

Information provided after the inspection showed that between August 2022 and July 2023, there were a total of 17 patients admitted to the Children's inpatients, who had an identified eating disorder requiring medical intervention and support.

The average length of stay for these patients were 24.2 days with the minimum length of stay being 2 days and a maximum of length of stay of 63 days.

During this time, 16 of these patients avoided admission to a tier 4 unit and were able to be discharged home from children's inpatients.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

The service and transition team worked very closely with the community team to ensure the children/ young person received the care needed and they worked together as a multiagency team with the young person's individual needs as the main priority.

The transition team worked closely with the community and adult teams to ensure young people's care was handed over and the care and treatment could continue to happen even though they had moved services.

Managers monitored and took action to minimise missed appointments.

The service told us they monitored missed appointments; however, they were unable to provide any data on how many were missed between July and September 2023. They stated they had a Standard Operating Procedure for entitled Children who were not brought to appointments had been authorised during the Paediatric Clinical Governance Meeting in August 2023. The service provided letters post inspection as evidence to show they write to patients to inform them that an appointment had been missed and what actions they were required to take. However, since our inspection the service have implemented procedures to monitor missed appointments, ensuring parents and GPs are notified.

Managers ensured that children, young people, and their families who did not attend appointments were contacted.

Services for children and young people

Meeting people's individual needs

The service were inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people, and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs.

The service had support from the mental health nurse, and they were also able to support children and young people with learning disabilities. The service also had support from a teacher, Play specialist and youth worker. The service also had support from the safeguarding team, occupational therapists, physiotherapists, dietitians, and psychologists on site.

The service had a transition team who liaised with community services and adult services to ensure children and young people and families got the support they required once discharged from the service.

The service held meetings every week on a Monday and Thursday in relation to children/young people who presented in the department with mental health concerns and cases were discussed between the community and the hospital, and feedback to the psychologist.

Wards were designed to meet the needs of children, young people, and their families.

The ward had been designed well and this include bays with 4 beds in and then side rooms. Staff ensured a bed was provided for a patient with learning disabilities or autism, to meet their individual needs. This ensure they were located in the quietest part of the ward, so they were not overstimulated.

Staff used transition plans to support young people moving on to adult services.

The service used documents called ready steady go and about me booklets to support young people who were transitioning from children's service to adult services.

The transition team told us they met with young people and their families when transitioning care over to the adult's team. Young people and families were encouraged to voice any concerns or worries they had.

Staff supported children and young people living with complex health care needs by using 'This is me' documents and passports.

The service used an "all about me booklet", this was written in Picture Exchange Communication System (PECS) it asked for preferred name, what I like to be called, preferred communication style, allergies, preferred administration method for medicines, what makes me anxious, pain management, what support is required relating to personal care, what support is needed to help me move around, any presenting behaviours, my likes and dislikes, and this is completed with the child and young person and families/carers.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

Services for children and young people

The service had an Interpretation and Translation Policy, the staff told us they had a good understanding of supporting children and young people with a disability.

The service had a Policy to Produce Patient/Carer Information Leaflets; however, the trust told us this policy was under review as the date on the policy needing reviewing in August 2023.

The service had information leaflets available in languages spoken by the children, young people, their families, and local community.

The service were able to access language line via the computer and printed any leaflets they required for children and young people and their families in their first language.

Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed.

The service told us if an interpreter or signers were required to be able to communicate with children/ young people and their families these could be requested as soon as the child/young person was admitted to the wards/units.

Children, young people, and their families were given a choice of food and drink to meet their cultural and religious preferences.

The service provided a choice of meals to meet the needs of the children and young people, hot meals were provided at lunch and tea with a choice of sandwich for tea also. Families also had access to a parent's kitchen where they were able to prepare their own meals, or warm food that had been brough from home.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to.

The service had an assessment unit where children and young people were assessed to see what intervention was required.

The service had a 3 times per day handover and discussed admissions and bed capacity.

During the inspection we witnessed staff assessing a young person who had been on the ward in relation to their medical and mental health concerns, and staying on the ward until they knew they were ready to be discharged home, meaning that this bed would be occupied, and the team knew when it would become available again.

The service worked closely with the transitions team to ensure children and young people were able to be discharged with the correct support whilst in the community.

The service monitored urgent referrals to the department which were discussed between the general practitioner and outside trust clinicians. The consultants of the assessment unit triaged children and young people and identified the best place for them to be reviewed. This includes reviews on the assessment unit same day or next day. The service had a paediatric rapid access clinic which were held weekly for children who may not require admission but needed to be seen urgently.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

The service monitored waiting times on the children assessment unit, for June 2023 the 15-minute waiting time targets had not been met, these were 83%. However, the data showed this had improved with compliance, reaching 98% in July and 100% in August 2023.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum.

The service monitored and collected data in relation to cancelled appointments/treatment and operations.

When children and young people had their appointments/treatments/ operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Post inspection the service provided us with data in relation to cancelled appointments, they shared 6 appointments/ operations that had been cancelled in 2023. Two of these operations had not met the 28 days re book policy, which was due to a patient not providing a urine sample and staff strike action. For the other 4 operations new dates were made and the operation took place on the identified date.

Managers and staff started planning each child and young person's discharge as early as possible.

The service discussed discharges daily and kept the child/young person and families up to date on their care and treatment.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs.

Staff worked with the young person, their family, CAMHS and the community team to ensure discharges were planned and appropriate. The ward had also introduced overnight stays at home to ensure the young person and families adjusted to being back in the home environment. They returned the next day to the ward and discussed how the home visit went.

Managers monitored patient transfers and followed national standards.

The service complete audits in paediatrics in relation to KIDS intensive care and decision support and in neonates in relation to the neonatal transfer service. These services are used when babies, and children and young people are deteriorating and require a transfer to a paediatric or neonatal intensive care unit. Between the months of July and September 2023 there had been 6 neonatal transfers to 3 different specialist neonatal hospitals.

The service had policies in relation to transferring children/ young people to another trust.

Services for children and young people

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Children, young people, and their families knew how to complain or raise concerns.

Parents and carers we spoke with told us when they raised concerns with the service, they felt their concerns were listened too.

Post inspection the service told us between 1 July 2023 and 30 September 2023 they had received 13 complaints, 7 of these were still open, and of the 5 that have been closed, 4 were partially upheld and one was not upheld.

Staff understood the policy on complaints and knew how to handle them.

Staff we spoke with during the inspection stated they understood the policy in relation to families and carers making complaints to the service.

Managers shared feedback from complaints with staff and learning were used to improve the service.

Managers shared feedback to the staff and identified themes and learning from the complaint, to be able to make changes to the service.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

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

Local leaders had the skills, knowledge, and experience to run the service. The senior team consisted of a Divisional Director of Operations, a Director of Midwifery, a Divisional Director of Nursing, and a Divisional Medical Director.

Staff told us local managers were supportive and approachable, they also stated they knew and saw senior managers as they visit the ward. They were supportive with their development and to develop their skills to enable staff to apply for promotions.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Services for children and young people

The trust had a vision and strategy which covered a 5-year period from 2022 to 2027. The focus was on their highlights which were identified as “where we are today” and what achievements had been completed. Then key Challenges and opportunities. Then the trust had “Where We Want to Be,” improving the delivery and quality of care, supporting our workforce, and embedding a culture of continuous improvement across the organisation. The final part of this was the trust look at “how will we get there.”

The strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans were monitored and reviewed.

Staff told us they had a good understanding of the vision and strategy, and this had been shared by managers with the staff team.

Managers told us when new staff were inducted the trusts strategy, vision, and values were part of the induction.

Both Neonatal and the children service had their own strategy for 2023 and 2024, these identified the areas they would be working on over the year.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

During the inspection staff told us there was a positive culture, and they felt this had got better when new staff had started working at the service.

Staff told us they felt supported by managers and could approach them if they had any concerns.

There were cooperative, supportive, and appreciative relationships among staff. Teams and staff worked collaboratively and shared responsibility.

The Baby Friendly Initiative Specialist Nurse who worked in neonates had been working to improve the experience for families, by achieving Baby Friendly Initiative accreditation stage 1 for infant feeding.

Staff had access to the freedom to speak up guardian, and managers were working with the Freedom to Speak Up to visit the wards/units, so they are more visible to staff.

Staff completed a staff survey and the service had identified the good practice and which areas scored high, which were,

- Compassionate Culture
- Equality, Diversity and Inclusion
- Able to raise concerns and share ideas for improvement.
- Development Opportunities
- Team Working

- Staff Engagement, Involvement and Motivation
- Advocacy

The service had also identified areas that needs to be improved, these were:

- Leadership / Compassionate Leadership
- Recognising and rewarding staff
- Autonomy, Control, Involvement in changes/improvements
- Burnout, Conflicting Demands, and Workload
- Appraisals
- Work-Life Balance / Flexible Working

The service had implemented an improvement plan which identified all areas that needed to be improved and how they were going to achieve this.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Children and young people's services' business and governance is discussed in the Paediatric business meeting and the Paediatric governance meetings. Neonatal services also have the same meeting's structure to discuss neonatal business and neonatal governance items. Business and governance from each area is further escalated and overseen by the Women and Children's Divisional Committee.

During the governance meetings the items discussed were risks/incidents/complaints, safeguarding training, risk register, serious incidents, and clinical audits with an update and action plan, and audits awaiting sign off.

The service held meetings with the Urgent and Emergency Care team to discuss children and young people who came into the hospital via the Emergency Department. Safeguarding, CAMHS, training and operational issues were discussed within this meeting.

The service completed an action plan for any actions that had been identified and these had a completion date and a responsible staff member. These were also Red, Amber and Green (RAG) rated, which meant each action had a colour red orange or green which showed which actions still needed to be completed and which ones had been completed.

The service stated post inspection that the paediatric triumvirates were developing a new audit guidelines for 2024/25; this would be closley monitored through Paediatric, Neonatal and Divisional Governance process.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk register in place and managers were aware of their top three risks.

The risk registers identified which wards/units were responsible for the risk and actions identified to mitigate this. For example: Supporting patients who attend the service with mental health concerns the service by meeting twice a week with the crisis team to ensure that support for the young person could be put into place.

The service would take risks off the register if there were agreements that the risk had reduced, and if a risk were to increase this would move up the register. The risk register had 13 risks identified within the service.

Managers reviewed the risk register monthly, this was overseen by the governance lead consultant and governance officers. Action plans were then developed with timescales to mitigate the risks identified.

The service had a process in place for the shortage of nursing and medical staff, the managers had a good oversight of the staff levels and where shortfalls were identified, they were able to seek bank or agency staff.

Information Management

The service did not always collect reliable data. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service told us that Neonatal did not collect data for 3 months, in relation to patient's outcomes. However, the paediatric wards and assessment unit did complete clinical audits and action plans to improve the quality of care provided.

Staff could access all policies and procedures on the trust's intranet. Staff also told us that they were involved in driving improvements. They demonstrated an understanding of where previously the quality of care had fallen below the trusts expectations, and felt they worked together as a team to raise standards.

Information Governance and Data Security Awareness training had been included in the trusts mandatory training schedule.

Data and clinical audits were discussed in the paediatric and Neonatal' governance meetings which had been taking place monthly.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff had the opportunity to participate in a staff survey, there were 9 questions asked in the women's and children's people promise survey and over 400 staff completed this.

Within the 2022 women's and children's people promise survey paediatrics had 3 scores that were above the trust score and 6 scores that were below the trust score.

Within the women's and children's people promise survey Neonatal had 3 scores that were above the trust score and 6 scores that were below the trust score.

Overall Neonatal had the lowest scores identified in the divisional summary report.

The service had implemented an improvement plan, this had what the results were, what they are going to do to work together to make this better, and this also identified who had responsibility.

Staff told us managers were visible and they felt supported by managers who worked directly on the ward.

The service had close liaisons with other teams, including Neonatal, the urgent care and emergency team, and community. Within these meetings the managers discuss guidelines and Standard Operating Procedures, this included training which could be delivered to help support consultants in the ED (Emergency Department) department to advance their knowledge with paediatrics care and treatment.

The service engages with patient users which include learning disabilities, mental health, eating disorder, diabetes groups. A formal Trust Children and Young People's Youth Experience Panel was in the process of being set up being facilitated by the Paediatric Directorate's Children and Young People youth worker.

The service had completed some away days and education groups for children and young people with diabetes and for children and young people who would not engage in their treatment or care. These visits included a visit to the farm and rock climbing.

The service currently did not hold equality groups, this was at the idea stage at the time of inspection.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

During this inspection there had been evidence that staff had a good understanding of mental health, the service had implemented an eating disorder care bundle and a mental health risk and safety booklet.

The service had built relationships with the local mental health team and community to enable them to support children and young people who may present as in crisis.

Managers told us they had raised the profile of Children and Young People within the trust, and this had better relationships between different departments.

A staff member who worked within paediatrics had been working to develop and improve the new sepsis and deterioration patient pathways. We found this had been well embedded and all staff were using this and were proud to tell us.

The service had recently completed the core syllabus for paediatric training and had been implemented on the 1 August 2023. This was for the purpose of training doctors to acquire a detailed knowledge and understanding of the health and illness in babies, children, and young people.

The service had developed how they monitored sepsis management and introduced a new system of RAG rated, and this was placed in the child/young person's records. Managers told us they have now implemented star of the month, where staff gain recognition of the work they are doing. This had been implemented as it had been identified in the staff survey that staff were not getting the recognition of their work.

Royal Shrewsbury Hospital

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

Description of this hospital

The Royal Shrewsbury Hospital is part of Shrewsbury and Telford Hospitals NHS Trust and provides acute services to those living in Shrewsbury and surrounding areas.

Services at the Royal Shrewsbury Hospital include urgent and emergency care services, emergency medicine and surgery and end of life care services. Along with diagnostic and screening, critical care and outpatient services.

The urgent and emergency care service provides services 24 hours a day, seven days a week. The service consists of a booking reception area, a main waiting area, a children's waiting area, two adult triage rooms, four bedded resuscitation bay, 12 majors' cubicles, 'pit stop' with four trolleys, four bedded clinical decisions unit (CDU), one children's cubicle and one children's triage room.

The hospital's medical care services comprised of cardiology, renal, respiratory and dermatology, stroke, care of the elderly and neurology, diabetes and endocrine, clinical support services, oncology and haematology.

The end of life care service comprised of two service lines, a specialist palliative care team and an end of life care team. The palliative care team at Shrewsbury and Telford Hospitals NHS Trust works across both hospitals. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

End of life care

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff. We found mandatory training included training in basic life support, infection prevention and medicine management training. The mandatory elements were repeated once a year on or near the same date where possible. All staff completed an induction programme. Since our 2021 inspection, the mandatory training compliance had improved.

Staff received and kept up to date with their mandatory training. End of life care was part of the trust's mandatory training programme. The Palliative and End of Life Care Team (PEoLC) had an 89% compliance rate with mandatory training, with the chaplaincy service at 100%, and the hospital porters at 88.4% against the trust target of 90%.

The trust used an electronic monitoring system to manage staff mandatory training on a yearly basis. Staff told us they were responsible for making sure they were up to date with all their training and could access their training records online. Staff were sent reminder emails when their training was due to expire. Staff told us they completed their mandatory training which was a mixture of face-to-face training and electronic learning packages.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training rates for medical and nursing staff were reported within the individual directorates. Staff who provided end of life care said they had received training in safeguarding children and vulnerable adults. Safeguarding training was part of the trust's mandatory training programme. The safeguarding training modules included level 1,2, and 3 adult safeguarding training and level 1 and 2 children safeguarding training. Data showed the PEoLC achieved 100% compliance rate for safeguarding training against the trust target of 90%.

Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise.

There were effective systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. There were up-to-date trust wide safeguarding policies and procedures, which were accessible to staff through the trust's intranet site.

End of life care

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All staff we spoke with had undergone training on the Equality Act as part of their mandatory training and were knowledgeable about the subject. Equality and diversity were promoted within the trust. Staff including those with particular protected characteristics under the Equality Act, told us they were treated equitably.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. End of life and palliative care patients were nursed throughout wards at Royal Shrewsbury Hospital including in 13 specified Swan Rooms on a range of different wards, including the Intensive Care Unit and in Emergency Department. Swan Rooms were dedicated side rooms on most of the wards for patients who were at end of life to use. Swan Rooms allowed people important to the patient, to spend time with them in a more peaceful environment. The mortuary waiting and viewing rooms were visibly clean.

The trust had an up-to-date infection prevention and control (IPC) policy, which provided guidance for staff on the prevention and control of infection. Risks associated with IPC following the death of a patient were contained in this guidance. Data showed 100% of porters had undertaken training on IPC, which was above the trust target of 90%.

Throughout end of life care, we observed staff complied with best practice with regard to IPC policies. Staff were observed to wash their hands or use hand sanitising gel between patient contact. This was in accordance with the World Health Organisations (WHO) five moments for hand hygiene. There was access to hand washing facilities on the inpatient wards.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves and aprons were available on all the wards we inspected and there were adequate resources of PPE for all staff to utilise when caring for patients. We observed all staff adhering to the bare below elbow policy. Staff prepared deceased patients on the ward for transfer to the mortuary. They were knowledgeable about the procedures to undertake for a patient who died with a contagious disease and would discuss this with the ward manager, IPC team or the staff from the mortuary. Staff were aware of cultural and religious differences in end of life care and would contact the chaplaincy for advice where required.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw equipment had been cleaned and ‘I am clean’ stickers were attached.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment safely. Staff managed clinical waste well.

Clinical waste and domestic waste bins were emptied by the cleaning staff on the ward area and disposed of through the trusts waste disposal procedures. Staff adhered to correct principle for managing and disposing of sharps. Sharps bins were correctly assembled and were not overfilled. All bins were observed to be below three quarters filled).

Patients could reach call bells and staff responded quickly when called. A call bell system was on all the wards we inspected for patients and care givers to ring when they required assistance from the nursing staff or in an emergency.

The service had suitable facilities to meet the needs of patients' families. Visiting the deceased adult patients was undertaken by appointment in a separate dedicated room from the children viewing room near the mortuary. The room was neutral of religion and people were afforded privacy to pay their respects to their loved ones.

The trust had 2 concealment covers called an X-Cubes. These were 3-dimensional frames with a cover which was placed over the deceased on the ward and on the bed in which they had died. This enabled the transfer of the deceased with a high level of privacy and dignity by the portering staff.

The service had enough suitable equipment to help them to safely care for patients. There was sufficient equipment available to meet the needs of people receiving end of life care and on all of the wards we visited. The trust used specialist syringe pumps for patients who required continuous infusion of medication to control their symptoms, and these met the current requirements of the Medicines and Healthcare Regulatory Agency for end of life care patients. Staff told us they did not have a store of their own syringe pumps; however, if they required one for a patient, staff from the medical equipment library were quick to provide them with one. Out of hours, there was a system for them to access the equipment library to collect a syringe pump. These were readily available and obtained from a trust wide medical device library. We visited the equipment library and observed there were many syringe pumps, which had all been collated and were ready for use. Grab and go' boxes were available across all wards which contained relevant equipment to make up 2 syringe pumps. Additional items of equipment including pressure relieving equipment, alternative beds (for example, high and low beds) and bed side rails were readily available for end of life care patients if required. Staff carried out daily safety checks of specialist equipment. The equipment we inspected was fit for purpose. Equipment used for resuscitation was visibly clean. There were resuscitation trolleys throughout the in-patient wards. We observed that these were accessible and had received the necessary daily and weekly checks and the equipment stored within resuscitation trolleys and grab bags were within expiration dates.

Single-use items of equipment were sealed and in date, and emergency equipment was dated to indicate it had been serviced. We saw records showing equipment was checked daily by staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life. However, not all ReSPECT forms we reviewed were completed appropriately.

The trust used the recognised National Early Warning Score assessment tool for recording the observations of patients admitted to the hospital. Early warning scores were developed to enable early recognition of a deteriorating patient. End of life care patients were assessed for how regularly observations were required and this was documented in their notes. We looked at 1 patient record and saw the patient had their early warning scores calculated appropriately. Staff knew how to recognise a deteriorating patient and how to escalate this. We observed nursing staff asking a member of the PEoLC to review a patient who had deteriorated and saw that the PEoLC team member reviewed the patient promptly when asked to do so.

Risks assessments for each patient were completed upon admission and were reviewed consistently. We reviewed 3 sets of patient records, which included up to date care plans and risk assessments.

End of life care

Staff were able to identify patients who were palliative or end of life and carry out a referral to the palliative and end of life care team if the needed to. The service had improved how referrals were undertaken by ward staff since the last inspection in 2021. The palliative and end of life care team introduced an electronic referral system in October 2022. These referrals were then RAG rated via the patient pain score and other symptoms management scores to determine how soon the patient would be reviewed.

Staff knew how to make a referral to the hospital palliative care team PEoLC to advise on care and advanced planning for patients at the end of their life. The team reviewed all patients admitted with a diagnosis of cancer receiving palliative care, and all other end of life patients who required assistance with pain control, had complex needs or who required specialist input to facilitate a speedy discharge home.

There were dedicated end of life care champions on every ward who provided specialist support on a day-to-day basis at ward level.

Staff from the palliative and end of life care team would undertake regular reviews of patients whilst they were inpatients. We saw evidence of these reviews in patient notes.

Staff knew about and dealt with any specific risk issues. The service undertook intentional rounding. This is an organised process where nurses carry out regular checks with individual patients at set times. During these checks, the nurses undertake scheduled or required tasks. For example, observations of patients; addressing patients' pain, re-positioning, and personal care needs; assessing and attending to the patient's comfort; and checking the environment for any risks to the patient's comfort or safety. Dependent on the individual patient's level of risk, these checks were conducted between 1 and 5 hourly intervals.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff knew how to refer to the mental health team for psychosocial assessments if a patient was a risk to themselves or others.

The service had 24-hour access to mental health liaison and specialist mental health support. The trust told us there had been no specialist mental health training for staff since before the pandemic. However, the mental health lead was now in discussions with the mental health liaison team (MHLT) who had agreed to recommence a rolling training programme, which would be monitored during joint governance meetings quarterly. Three separate dates in November had already been organised for training. The clinical lead within MHLT had also developed online training covering the referral process to the MHLT. This training was not mandatory, although discussions were taking place with the education department on making the e-learning mandatory.

Staff shared key information to keep patients safe when handing over their care to others. We saw evidence that during handover end of life care patients were discussed.

The trust had recently converted from a traditional do not attempt cardiopulmonary resuscitation (DNACPR) form to a new ReSPECT form. These documents recorded patient's wishes in regard to escalation of care (whether they wanted to be admitted to intensive care or remain on ward level care) if their condition deteriorated, their priorities relating to end of life care (for example, symptom control, preferred place of death), as well as the decision of whether they wished to be resuscitated. The ReSPECT form was transferrable across the health economy and when patients were discharged, they took with them the original document. Although the form was relatively new at the time of our inspection, staff had adapted well to these forms, and we found quite comprehensive details and answers on most of them.

End of life care

We reviewed the completion of ReSPECT forms on wards we visited. At the Royal Shrewsbury Hospital 16 out of 20 ReSPECT forms we reviewed were completed appropriately and required information was visible in the patients care notes. We highlighted where the issues were to ward staff and the forms were corrected the same day. The trust audited the use of ReSPECT forms across the trust quarterly. For the most recent audit in June 2023, the Royal Shrewsbury Hospital met 91.2% of the key areas for ReSPECT audit completion. This was an improvement since the last inspection in 2021.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff throughout the hospital delivered end of life and palliative care and were supported by a dedicated specialist palliative care and end of life team. Following the inspection in 2021 the service made the decision to merge the specialist palliative care and the end of life care teams to create one service. This team worked across both the Royal Shrewsbury Hospital and The Princess Royal Hospital. The service had enough nursing and support staff to keep patients safe.

The service had introduced 7-day palliative and end of life care service and embedded it to meet the minimum standard of the National Institute for Health and Care Excellence. This had improved since our 2021 inspection.

At our last inspection in 2021 we were concerned that the provider did not have enough staff. The service had since recruited additional nurses. The service had 6 full time band 7 nurses and 2 band 6 nurses (who worked 1.3 whole time equivalent WTE). Staff were managed by the matron for Oncology, Haematology & Palliative Care matron and supported by a band 8a End of Life Care Facilitator. The service currently had vacancies for a band 8b team leader to cover the whole service and a band 6 working 0.6 WTE. The PEoLC did not use bank and agency staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical staffing levels were reported within the individual directorates.

The service had enough medical staff to keep patients safe. At the previous inspection in 2021 medical staffing levels did not meet the minimum standard of the Royal College of Physicians (RCP), which required 1.4 WTE consultants based on the size of the trust. At this inspection, the service had recruited additional staffing and now met the RCP standards. The service had 3 palliative medicine specialist staff who worked an equivalent of 2.2 WTE. One of these staff members was shared with the local hospice.

The service had a vacancy for an additional specialist palliative medicine consultant working 0.8 WTE.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Since our last inspection record keeping had improved: a 'sema alert' system to aid communication between staff throughout the trust was introduced for when pateints were admitted

through accident and emergency and were known to the PEoLC. The alert remained in place after discharge, so that on future admissions, the admitting staff were made aware of the patinets status. For patients in the last days of life, the trust used a 'SWAN alert' for those patients cared for on the SWAN care plan, this meant that staff were aware the patient was receiving care in the last days of life.

We reviewed the medical and nursing notes of 3 patients who were receiving end of life care. The medical and notes were accurate, complete, legible, and up to date. They included detailed information about the management of symptoms, discussions and interventions. We saw that when the patient was seen by the PEoLC information and advice was clearly recorded so staff could easily access the guidance given.

An audit for the use of the ReSPECT forms was undertaken in November 2022 trust wide. Data showed that a total of 168 patients were identified as having a ReSPECT form across both acute hospital sites. Results were positive apart from, details of other relevant planning documents and where to find them, was only completed in 27% of cases overall (27.9% Royal Shrewsbury Hospital and 26.6% The Princess Royal Hospital), and the preferred name of the patient was completed on the form 47% of the time.

Managers used information from the audits to improve care and treatment. We were provided with examples of specific ward visits within the last year which resulted in changes.

Records were stored securely. Medical and nursing notes were stored securely on all the wards we inspected. We saw a risk assessment and care plan was in place for the 3 patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs. There was evidence of consent with regular updates recorded in medical and nursing notes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The service followed best practice and local policy when prescribing, dispensing, delivering, and monitoring medicines given to palliative and end of life care patients which included medications used in anticipatory prescribing. Anticipatory medicines are medicines which are prescribed for key symptoms associated with last days of life (for example, pain, agitation, excessive respiratory secretions, nausea and vomiting and breathlessness) and are prescribed in advance for rapid symptom relief.

Staff completed medicines records accurately and kept them up to date. We looked at 3 medicine charts of or an end of life care patients and saw the anticipatory medicines had been prescribed appropriately and in accordance with best practice.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff from the PEoLC told us as part of the ReSPECT process they discussed the patients' medicines with both the patient and care giver as appropriate.

Staff stored and managed all medicines and prescribing documents safely and in line with the trust policy. The trust pharmacy team and hospice medical team provided prescribing and medicine guidance 24-hours, 7 days a week. Staff told us that some patients required continuous medicines administration through a syringe driver to control their symptoms.

Staff were knowledgeable about syringe drivers and medicines administered via them. Staff told us some patients required more than one due to incompatibilities between some medicines. All staff were required to undergo specific competency training for managing a syringe pump, with a duration of supervised practice prior to being able to lead on this.

The trust had a detailed medicines management policy which was regularly reviewed, understood by relevant staff and specific to this service. Prescribers had access to local, regional and national prescribing guidelines relating to medicines used by the trust.

The PEoLC team had 6 WTE Specialist Nurses 4 of whom were non-medical prescribers, and one was undertaking training at the time of the inspection. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service had systems to monitor and manage accidents and incidents to maintain patient safety. Staff were aware of the process to report any incidents and accidents, and how to report them. At the Royal Shrewsbury Hospital between 1 October 2022 and 30 September 2023, there were 27 incidents in relation to end of life care.

The trust told us they had systems to ensure incidents related to end of life care were learnt from. The trust confirmed incidents were reported via their electronic incident reporting system with a specific flag for patients who were at the end of their life. Incidents were reviewed by the lead clinician and lead nurse for end of life care and responded to in a timely way.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Even though there had not been any serious incidents recently, managers told us they would speak to staff post serious incident and support them if they wished to either speak with the counselling service or the chaplaincy.

There was evidence that changes had been made because of feedback. In the previous 12 months the service had lots of evidence of positive changes they had made following learning from incidents. These included funding travel expenses for relatives who could not afford travel costs to visit their dying relative. The expansion of verification of death training for band 6 and above nurses and hospital at night practitioners to improve time taken to complete death verification. The palliative and end of life care team also put on additional sessions on pain management at continuous professional development events after a series of incidents.

Staff understood the duty of candour. Staff understood the duty of candour but were not able to give examples of where things had gone wrong as they could not remember when there was an incident involving duty of candour in the end of life care service. There was a standard operating procedure which provided guidance to the requirements of duty of candour.

End of life care

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff were clear of their roles in care pathways and were aware of the national guidelines relevant to their scope of practice.

New policies and procedures were communicated to staff through staff meetings, emails, and weekly updates. All wards we inspected had at least 1 end of life care champion who were able to provide staff with end of life care updates and support. All staff were able to demonstrate they received regular communication from team leaders and above. We found the trust's end of life individualised SWAN care plans were being used consistently throughout the hospital where patients were identified as end of life to ensure they received evidence-based end of life care. Staff were also able to tell us about the current National Institute for Health and Care Excellence guidance relating to end of life care.

For medical hydration document reviews, 89% of patients were shown to have received this. Medical hydration is intravenous hydration therapy which replenishes lost fluids when a patient requires rapid rehydration and/or is unable to hydrate adequately by drinking liquids or through intestinal absorption due to a medical condition. The audit outcomes showed an improvement in several of the areas audited compared to the same audit undertaken in 2022. For example, anticipatory medication prescribing, and medical interventions increased from 75% in 2022 to 96%, with medical hydration increasing from 66% in 2022 to 89% in 2023.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. They used hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Protected meals times were on all the wards we visited. We observed end of life care patients had access to drinks which were within their reach.

The trust used a red tray system when serving meals to patients. A red tray is used on the wards, to help staff identify which patients need extra attention when eating or need foods that have a modified texture (such as mashed or pureed foods). The aim of using a red tray is to monitor and help these patients when eating so their dietary needs are met.

We saw evidence on the intentional rounding chart that nurses regularly offered patients drinks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed patient's fluid balance charts and noted had been completed correctly.

End of life care

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw the Malnutrition Universal Screening Tool (MUST) being used. This is a universal five-step tool to identify adults who are malnourished, at risk of malnutrition or obese.

Specialist support from staff, such as dietitians and speech and language therapists, was available for patients who needed it. Staff had access to dietetic services Monday to Friday.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff on the wards used also utilised The Abbey Pain Scale, which is a pain assessment tool developed for use with patients who are not able to verbalise their level of pain. We saw staff considered adequate pain relief for end of life care patients to be a priority and where needed, they sought guidance and input from the Palliative and End of Life Care Team (PEoLC).

We saw evidence of patients regularly being assessed for pain and given medicines in a timely fashion. For example, we saw an end of life care patient on a ward who had been prescribed anticipatory medicine by the PEoLC, which included medicine for breakthrough pain. Breakthrough pain may come on suddenly and can occur in between regular, planned pain relief. Staff told us everyone who was recognised as being at the end of life were prescribed anticipatory medication. (Medication that patients may need to take to make them more comfortable).

Medicines were given by a syringe driver where the oral route had become inappropriate, and symptoms had become continuous.

Staff confirmed syringe drivers were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief. The trust had a syringe driver tracking system and checklist for when the syringe driver was used for administration of medication. There was a monitoring of infusion section which stated it must be completed on a 4 hourly basis when the syringe driver was in use.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations. Managers and staff used the results to improve patients' outcomes. At our last inspection in 2021 we were concerned that the provider did not have a specific end of life care dashboard to give an overview of quality metrics and key performance indicators. The service had developed and introduced this dashboard, which included audit outcomes, so it could measure its impact at ward level.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. The service undertook 'Ask 5' audits, which included themed questions about preferred place of death discussions, taste for pleasure, syringe pump driver access and various pain control measures.

End of life care

The service participated in relevant national clinical audits. The service had an end of life care and survey work plan, which included several audits concerning end of life care. For example, the care after death audit which was undertaken annually and in conjunction with the mortuary to assess and improve quality of care after death and the symptom control audit which assessed pain and symptom control in end of life care patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Staff demonstrated a good knowledge of safeguarding, infection control and mental capacity assessments. They understood how to support people to make decisions for themselves and how to achieve this.

Managers gave all new staff joining the palliative and end of life care team a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates were reported within the individual directorates. Appraisal rates for the PEoLC were 100%, which was above the provider target of 90%. Staff told us meaningful appraisals were undertaken regularly and were positive about the appraisal system.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The trust had suitable provision in place to ensure staff received regular supervision and 1-to-1 support. There were systems to ensure nurses and medical staff could meet the requirements for revalidation. Staff were knowledgeable about the trusts clinical supervision policy and the benefits of regular supervision.

The clinical educators supported the learning and development needs of staff. The end of life care facilitator and the PEoLC attended and facilitated training events across the trust. Courses attended included current issues in palliative care, dying matters, and other end of life characteristics.

Staff told us they received training through e-learning as well as face to face teaching. Staff were positive about the training they received, they told us they had received in-depth training in end of life care and felt they were competent to undertake their work within the service. There was a range of developmental training available, and staff told us they had been supported by the trust with their continuing professional development. This had improved since our 2021 inspection.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they felt supported to pursue additional training to develop professionally. For example, 1 staff member told us they had been supported to undergo non-medical prescriber training.

All staff told us they felt very well supported and competent to fulfil their role.

Multidisciplinary working

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

End of life care

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We attended a multidisciplinary meeting and observed all members of the multidisciplinary team worked and interacted well with each other to enable a coordinated approach to the way in which care was delivered. We saw evidence of regular input from the dietitian, occupational therapist, and physiotherapist, involved in the care and treatment of end of life and palliative care patients. Staff worked closely and effectively together with a culture of respect for each other's roles.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they worked in partnership with external providers of end of life care in assessing, planning, and delivering care and treatment. This included the local hospice, GP's, primary care nursing teams, allied health professionals and social care providers, all relevant teams, services and organisations were informed if people were discharged from the service.

In accordance with the Gold Standards Framework, multi-disciplinary meetings took place weekly to ensure any changes to patients needs could be addressed promptly.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff told us they worked in partnership with external providers of end of life care in assessing, planning, and delivering care and treatment. This included the local hospice, GP's, primary care nursing teams, allied health professionals and social care providers. All relevant teams, services, and organisations were informed if people were discharged from the service.

Staff said that patients referred to the PEoLC were seen promptly and reviewed on a daily basis. Since our last inspection, there had been improvements in the triaging of referrals by the PEoLC. There was a new Red, Amber, Green (RAG) rated triage referral system, to ensure those patients in the most need were seen first. There were a number of medical and health issues the triage form covered, for example, pain, nausea, and vomiting. When assessing a referral if a patient was in severe pain, the PEoLC would see the patient within 4 hours. If a patient was in moderate pain, 24 hours and mild pain, 48 hours. However, if the same patient had 2 moderate categories, this would be escalated to a 'Red' review and this meant a response of within 4 hours would be undertaken.

Nursing staff on the wards we spoke to as part of our inspection said the Palliative and End of Life care team always responded promptly within the patient timescales.

Data for the period April 2022 to March 2023 across both sites showed that of the 1,378 patients referred to the PEoLC, 421 (30%) were triaged to an urgent 4-hour response time, of these 421 patients, 394 (93.6%) were seen within the 4 hour window.

Board rounds took place on the wards daily where patients who required a fast track or rapid discharge pathway were discussed. The PEoLC told us they had an effective relationship with the local hospice and ensured that patients nearing the end of life were referred to the hospice in a timely fashion as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff told us they knew how to access the specialist mental health team if they were needed on a 24 hour basis. Staff shared essential information to keep patients safe when handing over their care to others and when patients moved between wards or for end of life care patients transferred to the community.

End of life care

Seven-day services

Most key services were available 7 days a week to support timely patient care.

The palliative and end of life care team provided a service from 8:30am to 5:30pm, 7 days per week based at The Princess Royal Hospital site. Outside of these hours, there was a dedicated advice line at the local hospice for specialist advice.

End of life care was provided by general nurses and medical staff on the wards throughout the hospital 24 hours a day. The trust had implemented the SWAN model of care and had recruited and trained end of life care champions. There were between 1 and 4 champions on each ward who attended palliative care meetings and cascaded information to staff at ward level.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could request for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

The chaplaincy service provided pastoral and spiritual support and was contactable out of hours. The multi-faith facilities were available to patients, visitors, and staff 24 hours a day.

The mortuary was open 8am to 4pm Monday to Friday. Staff are on call between 9am and 10am every Saturday and Sunday and Bank holidays and then can book appointments from 10.30am to 2pm. Porters can access mortuary 24/7 (to allow emergency services, and funeral companies access).

Bereavement services were open Monday to Friday and an out of hours service was available for cases at the discretion and availability of the staff on duty.

An out of hours viewing service was provided by the mortuary for cases at the discretion and

availability of the staff on duty.

Not all therapies were available 7 days a week.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on wards. We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff used the initial assessment documentation.

End of life boxes contained information to support patients and their families across a range of areas. For example, eating and drinking at end of life and supported staff to enable individuals to live a healthier lifestyle.

End of life care

We saw information support centres in the hospital, offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, ReSPECT forms were not always completed appropriately.

Mental Capacity Act and Deprivation of Liberty Safeguards training rates were reported within the individual directorates.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. Staff received training on mental capacity assessments and Depravation of Liberty Safeguards as part of their mandatory training.

Nursing and medical staff told us they had received training on the Mental Capacity Act and how to complete mental capacity assessment as part of their mandatory training. Doctors completed the mental capacity assessments, even though nurses and allied health professionals were also trained to do so by the trust.

We looked at 14 ReSPECT forms across the hospital and found there were inconsistencies in how these were completed. We found that out of 14 ReSPECT forms, 5 were not completed correctly (37%). We found staff had not always followed trust policy when they completed ReSPECT forms and ReSPECT forms were not completed accurately for several reasons. These included.

- A lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and or their families and care givers.
- ReSPECT forms which were not signed by the senior clinician as well as lack of discussion with the patient.
- ReSPECT forms from the community which had not been reviewed or updated.

We escalated the incorrect ReSPECT forms to the trust and they were corrected by the end of the day

We did not see anyone under a Deprivation of Liberty Safeguards during this inspection.

The trust undertook an audit of mental capacity assessments for both sites for the period December 2022 to February 2023. In total 40 patient records were randomly chosen and reviewed, 20 at the Royal Shrewsbury Hospital and 20 from The Princess Royal Hospital. Data showed an overall compliance rate of 96% with an overall compliance rate of 100% for Deprivation of Liberty Safeguards completion.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Patients and relatives told us staff did not provide any care without first asking their permission. Signed consent forms were evident in most of the patient records we examined. Staff clearly recorded consent in the patients' records.

All the patient records we looked at, we saw consent to treatment was obtained verbally and recorded in the nursing care record. This included member of the multidisciplinary team caring for patients.

End of life care

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients said staff treated them well and with kindness. We heard staff speak about the patients they cared for with compassion, dignity, and respect. We observed all staff members speaking to patients and their relatives and care givers with compassion and we observed sensitivity being shown during those conversations.

Staff followed policy to keep patient care and treatment confidential. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. Privacy and confidentiality was maintained throughout their admission. We observed staff drawing curtains around patients when providing personal care, and ensuring any confidential conversations were completed in rooms away from other patients and relatives on the ward. Compassion, dignity, and respect by all staff, including the transfer of the deceased patient to the mortuary. We spoke with the relatives of one patient who were receiving end of life care. The relatives described the care and support as excellent and said they felt well informed by the staff.

The mortuary porters told us they always treated the deceased with the greatest of respect when transferring them from the ward to the mortuary and could describe the process of collecting the deceased from the ward.

The trust had a bereavement service and staff who provided support for relatives, following the death of a patient. There was a relative's room on most wards where more sensitive conversations could be undertaken. Normal visiting times were waived for relatives of patients who were at their end of life.

The chaplain told us they could assist the nursing staff to ensure care and treatment was provided to patients with due regard to their religious persuasion.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. In the intensive care unit, staff told us patients who were in side rooms, were encouraged to bring their dogs from home to come and visit them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We attended a nursing handover on one of the wards we inspected. We observed staff discussing patients with mental health needs. Staff were respectful in their discussions and showed empathy and understanding.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The trust had a comprehensive chaplaincy service, team, and facilities for all faiths and none. The chaplaincy team were very motivated to provide a high level of support for all. They told us they always went the extra mile to help people who were dying and grieving relatives as well as supporting staff.

End of life care

There was a multifaith centre within the chaplaincy service where patients, loved ones, relatives and staff could visit.

The chaplaincy team were aware of which patients within the hospital who were identified as being at the end of their life and visited these wards daily or more often to offer support. They also offered support to families coping with caring for their loves ones and who were experiencing bereavement and were able to contact any faith leader within the community to provide support in hospital where required.

Although not licensed to conduct weddings for end of life care patients, the chaplaincy team could facilitate weddings with a community registrar very quickly if required.

Volunteers were used to escort patients to religious services in the hospital or sit with end of life care patients as required. All volunteers received training from the chaplaincy team and were observed in their practice.

Porters told us the ward staff treated the deceased with dignity and respect before they were transferred to the mortuary. Nurses undertook what is known as 'care after death', this is the procedure performed by nurses to the deceased shortly after death has been confirmed and is the process where the deceased is prepared for transfer to the mortuary.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The palliative and end of life team had recently developed complimentary support boxes, which were offered to families at the discretion of ward staff. Boxes contained woollen kindness hearts, drinks vouchers, parking discounts and support and advice. All wards we visited were able to provide these boxes. We spoke to relatives of patients who were receiving end of life care, all of the relatives we spoke to told us staff were supportive.

Staff supported patients and relatives who became distressed in an open environment and helped them maintain their privacy and dignity. Wards we visited had a relative's room, as well as SWAN room which staff could utilise for patients who were end of life and their families when it was required. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The bereavement survey results were collated on a quarterly basis. This data was not split to hospital level, so this data covered the whole trust. The bereavement survey feedback dated September 2023 stated found that 84% of families felt they were given the right amount of support or more support than was needed during their relatives end of life care.

Staff demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand.

End of life care

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were offered bereavement survey data in order to provide feedback. Families were also aware of the trust's complaints process.

The bereavement survey feedback dated September 2023 stated that 90% of families felt they had enough time to ask staff questions. Eighty one percent of families also felt they had the opportunity to talk to anyone about any concerns.

Staff supported patients and relatives to make advanced and informed decisions about their care, including preferred place of death. In records we reviewed and conversations with relatives we observed and heard that advanced decisions about patient care were made proactively.

Throughout our inspection, we observed staff were non-judgemental in their approach to the care of patients and families. For example, we observed staff explaining medication to a person who had a learning disability using language the person understood and also taking extra time to explain the medication in detail and answer questions.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. The service had introduced an electronic referral system for ward staff and had increased staffing levels within the team. This was an improvement since the last inspection in 2021 as this was not in place.

The service had introduced a triage system which ensured patients received support in a timely manner and could mean inappropriate referrals could be identified. This was an improvement since the last inspection in 2021.

The service worked closely with the local hospice, relying on their telephone advice line out of hours when no specialist hospital team was available. The service also shared staff with the local hospice.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had staff members to aid the delivery of care to patients in need of additional support. For example, end of life and dementia link staff, champions and learning disability link nurses. The chaplaincy team, which included volunteers, regularly visited significant ward areas, such as the emergency department and the intensive care unit and visited all those patients who had been placed on the individualised end of life care plans and people who wanted to see the chaplain.

Wards were designed to meet the needs of patients living with dementia. Patients with dementia were offered “Butterfly Boxes”, a small finger food box containing small portions of finger food patients could eat throughout the day, when assessed as safe to do so.

The service had information leaflets available in languages spoken by the patients and local community. The trust had access to a translation service to meet the needs of those whose first language was not English. Information leaflets could be adapted to braille and other languages and formats as required. Staff had access to translators if required.

In the critical and intensive care units, all patients had a patient diary completed by staff, family and loved ones, so when they left the unit, they would know what had happened as patients often have no memory of the time spent in critical care.

Relatives and friends of a patient in their last days of life were given a SWAN pack by the nursing staff on the wards. In the pack it explained what the SWAN Model of Care was and what to expect in the last days of life. For example, eating and drinking at the end of life, a leaflet on communication, medicine, and support for the people important to the person who was in their last days of life. The pack also contained a packed of Forget-Me-Not seeds to plant and a packet of tissues.

We saw on the wards we inspected that each ward had ‘Kindness hearts’, these were red knitted hearts, 1 heart was given to the patient and 1 to the relatives or loved ones.

The bereavement service provided a bereavement pack they gave to relatives of the person who had died. The pack contained a number of different booklets and leaflets to enable the relatives and loved ones ‘manage their loss a little easier. For example, there was a booklet on ‘Coping with grief’ which gave an account what to expect when you are grieving, a ‘Stop mail’ leaflet and a booklet called “Practical help and support for relatives and friends following the death of a loved one”. Additionally, all packs had card with a picture of a lily on the front from the bereavement office offering their condolences, with the message “Our thoughts are with you at this sad time”.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Nursing staff described how they encouraged patients to eat by involving the family to help choose their menu. Menu choices were available to reflect patients’ religious and cultural preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. At the previous inspection in 2021 the provider did not offer a 7-day service, but this had since been introduced and was embedded within the service. Between 1 October 2022 and 30 September 2023, the service saw 22% of patients across the trust who died this data was not split to hospital level. However, this included patients receiving acute treatment and resus events who would not have been suitable for referral. The service had a target to see all patients within 24 hours maximum. Between 1 October 2022 and 30 September 2023, the service achieved this for 93% of patients across the trust.

End of life care

Managers and staff worked to make sure that they started discharge planning as early as possible. Between 1 April 2022 and 31 March 2023, of the patients known to the palliative care team when inappropriate patients were removed, 80% achieved their preferred place of death.

Staff planned patients' discharge. Patients nearing the end of their life could be referred to a fast-track discharge pathway, with a target of getting a patient to their preferred place within 48 hours. These discharges were undertaken by the integrated discharge team who worked 7 days a week. At the Royal Shrewsbury Hospital between 1 October 2022 and 30 September 2023, the service had discharged 408 patients with an average of 4 days for the discharge. However, the service had difficulties arranging transport for patients from Wales, which we were told led to extra delays.

Managers monitored patient transfers and followed national standards. The trust engaged with their Integrated Care Board for NHS Continuing Health Care funding to enable some patients to be discharged home using a fast track discharge for those patients who were in the last weeks of life and a rapid discharge for those patients identified to be in the last days or hours of life. Staff told us that some discharges often took around a week but could be achieved more quickly when necessary. Discharges were occasionally delayed by the challenges faced with providing suitable transport.

Staff we spoke with explained that the fast track system was very dependent on the resources available locally and that it sometimes did not happen due to lack of resources in the community. For example, a lack of places at the local hospice. The trust did not audit performance on this process.

For the period October 2022 to September 2023, across both acute hospital sites the PEoLC received a total of 1,193 referrals, 746 referrals, were for patients with a cancer diagnosis and 450 were for a non-cancer diagnosis. This equated to 63% for patient cancer diagnosis and 37% for a non-cancer patient diagnosis.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives, and carers knew how to complain or raise concerns.

There were posters in ward areas which told patients and their representatives how to make a complaint and information on the trust website. Relatives told us they would feel comfortable raising a complaint with the ward or the complaints service if necessary.

Staff understood the policy on complaints and knew how to handle them. They told us they would advise patients to go to the patient experience team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained. Staff told us if a patient or relative had concerns about the care being delivered, they would try and address the issue at the time to resolve the concerns as quickly as possible.

Managers investigated complaints and identified themes. For the period October 2022 to September 2023, data across both sites, as this was not separated to individual hospital showed there was a total of 60 complaints and 84 compliments for the PEoLC team. Themes included recognising dying, communication with patient and families during dying and the ReSPECT process. We were told the trust clinical leadership was aware that improvements in the ReSPECT process was required and a working group was established with representation from the divisions and Learning from Deaths and Resuscitation teams as well as PEoLC team. Since the working group a clinical lead role for ReSPECT was being developed. Detail on the narrative of complaints was included in a report to the steering group each month.

End of life care

The clinical lead for PEoLC supported investigations and responses where needed, including when the PEOLC team was not involved. For example, the clinical lead supported a ward manager and matron in a face-to-face response where it was identified the patient should have been referred to the PEOLC team earlier. This case further informed the process of switching from telephone referrals to electronic referrals to the PEOLC team. Electronic referrals (started October/ November 2022) were quickly embedded and the risk of a delay in referral reduced as a result.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Is the service well-led?

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a clear leadership structure. A non-executive director and the director of nursing, midwifery and quality held overall leadership responsibility for end of life care and specialist palliative care services.

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff in the palliative and end of life care team spoke positively about leaders and the support they received.

The service expanded the palliative and end of life care steering group which now contained mortuary, chaplaincy and bereavement service staff alongside palliative and end of life care team. This was an improvement since our last inspection in 2021 when staff felt disconnected.

Leaders were aware of and could articulate the current issues faced by the service and had undertaken a large programme of work since the last inspection to manage these issues and improve the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

Since our last inspection, we saw there had been improvements with the end of life care strategy. The trust had created a new Palliative and End of Life Care Strategy for 2023-2026 which they were in the process of launching at the time of this inspection. The strategy document set out the commitment of the trust that people nearing the end of their life would receive high quality care and would be supported to live well and die with dignity in their place of choosing.

The strategy set out 10 aims underpinned by sub-assertions. Progress would be monitored by the trust's Palliative and End of Life Care Steering Group, which had representation from Non-Executive Directors. Monthly updates would be provided to the Quality and Patient Safety Committee who reported to the Trust Board of Directors.

End of life care

The trust had adopted the SWAN scheme, a national model of care and an acronym for signs, words, actions and needs in the care of the dying. Many of the staff we spoke with thought the SWAN emblem was a sign of tranquillity and peace, and not an acronym. One doctor we spoke with on a ward did not know the ward had a SWAN room or what it was used for.

Champions New for 2023 had been running Champion Cafes, led by the Swan Nurses. These were sessions that could be attended throughout the year. They encouraged an open dialogue between the clinical team and those Champions in the wards/departments. This encourages them to network with other Champions in the trust and supports service development. The platform enabled the clinical team to support those Champions if they needed emotional support or debriefing. It is early days and attendance at the Champion Cafés had been poor to date, these sessions were expected to continue and be reviewed in 2024.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Ward staff were focussed on the needs of the patient's receiving palliative and end of life care. Ward staff felt well supported by the palliative and end of life care team. At the previous inspection in 2021 end of life care was not a tangible priority on wards. Ward staff were not fully engaged in making dying everyone's responsibility. This was reflected in us finding that in more than one area, staff did not recognise patients under their care as end of life or palliative, even when prompted. There had been a lot of work undertaken by the palliative and end of life care since the 2021 inspection. Ward staff we spoke to were clear about their responsibilities and we could see ward staff providing good care to palliative and end of life patients.

Staff within the palliative and end of life care team told us they felt valued and respected.

The service had an open culture where patients, their families and staff could raise concerns without fear. Palliative and end of life care team staff told us they could raise concerns openly with leaders. The service distributed a sensitively worded feedback questionnaire to bereaved relatives of patients who have died at the trust. Quarterly and annual reports were shared through palliative and end of life care steering group and feedback metrics were reported on the dashboard.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders had improved the governance services across the trust since the previous inspection. The service worked with partner organisations. The service had introduced and signed a service level agreement with their local hospice to provide mutual support to help both services. This agreement ensured that the hospice provided a consultant-led, on-call, out-of-hours telephone advisory service for palliative care. This was not in place at the previous inspection in 2021.

Staff had clear opportunities to meet and discuss the service with clear objectives. Since the last inspection in October inspection the palliative and end of life care group had expanded and included representatives from palliative care team

along with mortuary, chaplaincy and bereavement service. The group had introduced clear and defined terms of reference. The group produced a quarterly report for the Quality Operational Committee (QOC) and an annual written report of its activities is produced and presented to the steering group, QOC and the Quality and Safety assurance committee.

We reviewed the meeting minutes between February and September 2023. The minutes clearly demonstrated the terms of reference were being followed, every meeting was quorate and included a review of the previous actions. Each meeting included a case presentation, a review of the dashboard, learning, patient feedback, divisional reports and audits. Actions were clearly identified and had staff assigned to them.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Leaders identified relevant risks and issues within the service. Similarly, to the previous inspection in 2021 the team did not hold their own separate risk register and it sat within haematology. There were currently 3 open risks which we saw were reviewed at PEoLC steering group meetings and added to the risk register as a result.

The risks listed were risks to the End of Life Care Service as a result of shortage of specialist consultant input, delay in patient transfer from ward to SWAN bereavement suite and devices (such as cannulas and lines) not being removed prior to being received by funeral directors. Risks were RAG rated and had clear evidence of being reviewed on a regular basis.

Leaders and teams used systems to manage performance. The service had the dashboard system in place to monitor end of life care performance at ward level. This was then used to target specific areas on wards in order to drive improvement in performance.

However, the trust did not audit performance on the fast track system and therefore could not manage performance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service used reliable data to monitor performance or quality. The service had developed and introduced this dashboard so it could measure its impact at ward level. The information was accessible and allowed staff to provide targeted support to specific wards for specific risks. This was an improvement from the previous inspection.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The PEoLC team engaged well to meet the needs and requirements of their patients and families and celebrated the good working relationships with the families they cared for. We saw evidence of where patients and families had thanked and praised staff for their care. We saw examples on the wards where staff had been involved in making positive change. For example, all the staff we spoke with were able to identify their end-of-life care (EOLC) champions and told us they felt communicated well with them.

End of life care

The service conducted a bereavement survey which was sent to a patient's next of kin following a death to collect feedback on the patient and relative experience. The results of the surveys were discussed in the end of life steering group meetings.

The EOLC champions provided ongoing on-the-spot advice and information to staff caring for patients every day. They kept a visual display of information on wall boards on each ward and were committed and motivated to ensuring the vision and strategy were being delivered 'on the ground'.

The trust encouraged all staff to attend EOLC events and conferences which were funded by the trust.

All staff we spoke with told us they felt the PEoLC was a supportive team. Staff interacted in a supportive way within the team to ensure safety and efficiency for patient care and there was a positive atmosphere within the team, even during very busy periods.

The trust contributed to the wider system end of life care group and collaborated closely with local end of life care providers, for example commissioners and local hospice providers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff we spoke with committed to continually learning and improving services. As mentioned throughout the report leaders and staff had made lots of improvements across the service since the last inspection. It was clear that staff understood quality improvements methods and had the skill to use them.

The service had introduced a complementary therapy service, a member of staff came from the local hospice to provide treatments to palliative and end of life care patients for 1.5 days a week. This provided moments for relaxation for patients and allows to staff to start conversation around hospice care post hospital admission.

The service had created and rolled out a care after death training video. The video was produced by the palliative and end of life care team and the communications department following findings from the audit programme. The video was designed in such a way in could be watched just prior to delivering care after death for ward staff who did not do this very often.

The service had introduced a red, amber, and green (RAG) rated system which helped identify patients in need of a more rapid review and treatment. This included a severe score which indicated a patient needed to be seen within four hours. It also meant all referrals were handled on a consistent basis.

The service had introduced palliative care review sticker notes to improve consistency in reporting within patients' records. These were seen to be in use across both hospitals and all wards we visited.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Medical staff were 85% compliant with mandatory training, which did not meet trust target. Nursing and medical staff was below the trust target of 90% for basic life support training.

Nursing staff received and kept up to date with their mandatory training. Data provided by the trust showed that 93% of nursing staff were compliant with their mandatory training requirements. The trust target was 90%..

Medical staff received mandatory training. Data provided showed that 85% of medical staff were compliant with their mandatory training requirements which was below the trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training topics included fire safety, infection prevention and control, moving and handling, adult basic life support, conflict resolution, equality and diversity and health safety and welfare. Most training sessions were completed as online learning.

Managers monitored mandatory training and alerted staff when they needed to update their training. Some managers acknowledged that training compliance was currently slightly lower than targets but were aware that staff were often too busy during work hours to undertake this training. Staff had access to protected learning time to help staff complete their training and managers were able to pay staff when training was completed outside normal working hours.

Adult basic life support (BLS) was part of the trusts mandatory training programme. Data provided by the trust showed 87% of nursing staff had completed BLS training and 76% of medical staff had BLS training which was below the trust target of 90%.

The trust advised advanced life support (ALS) and intermediate life support (ILS) training was not part of the mandatory training programme and the training requirement to complete this training was included in job descriptions and person specifications. Members of the cardiac arrest team are expected to be ALS trained and staff within acute areas to have ILS. Data provided by the trust showed that 15 medical and nursing staff had completed ALS training and 14 nurses had completed e-ALS. However, as ALS and ILS were not captured on the trusts learning management system, we were not assured the trust had full oversight of who had completed the training.

The trust also advised all new foundation year 1 (FY1) doctors were booked onto ALS when they join the trust. However, the trust commented that there was a shortage of ALS courses because they were resource heavy. The trust was putting on extra weekend courses to make up the shortfall.

The trust also ran e-Advanced Life Support (e-ALS) courses for those who had completed the initial 2 day course, face-to-face, and were required to update their skills.

Medical care (including older people's care)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff training for safeguarding children and adults' level 3 was below the trust target of 90%.

Safeguarding children and adults formed part of the mandatory training programme for staff.

Nursing staff received training specific for their role on how to recognise and report abuse. Data provided by the trust showed 98% of staff had received training in safeguarding children level 1 and 94% had completed safeguarding level 2 training. Compliance for safeguarding adults' level 1 was 98%, level 2 94% and level 3 95% which exceeded the hospital's target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse. Data provided by the trust showed 96% of medical staff had received training in children level 1, 83% had completed safeguarding children level 2 training and 40% had completed safeguarding children level 3, which was below the trust target of 90%. Compliance for safeguarding adults' level 1 was 94%, level 2 94% and level 3 83%.

Staff knew how to identify adults at risk of, or suffering, significant harm and were able to provide examples of concerns that had been raised. Staff knew how to make a safeguarding referral and who to inform if they had concerns and could access support from the service's safeguarding lead if needed. Staff we spoke with were aware of their responsibility to protect vulnerable children and adults and demonstrated a good understanding and knowledge of the types of abuse patients may experience.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Across the medical wards a total of 36 safeguarding referrals had been made in the last 12 months.

The hospital had designated safeguarding leads for adults and children.

The trust had a procedure for safeguarding adults at risk and the Deprivation of Liberty Safeguards (DoLS) which was due to be reviewed in December 2023.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were generally clean and well-maintained. Monthly infection prevention and control (IPC) and environmental audits for the period July to September 2023 showed most of the wards met or exceed the trust target of 90%. IPC action plans were in place where issues had been identified. Data showed that outstanding actions had been completed within the target date or were in progress.

Housekeeping staff were visible on the wards and were observed cleaning throughout the day. Cleaning records were generally up to date in those areas were records were kept, Staff cleaned equipment after patient contact and 'I am clean' stickers had been dated and were visible on all the wards to indicate the equipment had been cleaned and was ready for use.

We saw that there were hand hygiene posters above clinical handwashing sinks that reminded staff of effective hand washing techniques. Hand hygiene audits for the wards for the period of July to September 2023 showed most of the

wards exceeded the trust target of 90%. Staff followed infection control principles including the use of personal protective equipment. We noted most staff adhered to the hand hygiene, “bare below the elbows” and hospitals uniform protocol in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice. Sanitising gel was available on most wards. At bedsides we observed there were hand gels available.

Matrons undertook quarterly quality wards, data provided showed the wards met or exceeded the trust target of 90% in quarter 1 (April to June 2023). In quarter 2 (July to September 2023), 4 of the wards (wards 21, 26, 27 and 28) scored less than 90%, however, following a re-audit of 2 wards they scored 90% or more.

Hospital acquired infection rates from April to September 2023 for the Royal Shrewsbury Hospital (RSH), showed there were no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), 3 cases of Methicillin-susceptible Staphylococcus Aureus (MSSA), 9 cases of clostridium difficile (C. Diff) and 10 cases of Escherichia coli (E. coli). The non-elective screen rate for MRSA was 93.7%.

IPC was part of the trust’s mandatory training programme. Data provided by the trust showed 100% of nursing staff had completed level 1 IPC training, 87% had completed IPC level 2 training and 89% of medical staff had completed IPC level 2 training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Wards consisted of 4 or 6 bedded bays and side rooms, the bays were single sex with access to a shared toilet and shower room. We found ward bays and corridors were generally kept clear of equipment. On 1 of the escalation wards we found there was a lack of equipment. For example, there were a limited number of tables for patients’ food and drinks. The discharge lounge had a seated area and 2 side rooms to accommodate beds. We found the dirty utility room also had a store cupboard for clean equipment, such as syringes, bandages, and masks. However, since the inspection the Trust has closed the escalation ward (ward 21) and advised they are working on developing standardised equipment lists to set up safe, equipped escalation wards if they are required in the future.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Resuscitation trolleys were located on each ward, and we saw they were checked daily and the contents of drawers were checked weekly. However, on 2 wards we found that daily checks had not been completed for 3 days, this was raised with staff at the time.

Electrical medical equipment had registration labels affixed. Portable Appliance Testing labels were attached to medical equipment. However, not all the blood pressure machines and electrocardiogram (ECG) machines had labels attached. The trust oversaw the maintenance of equipment and maintained the medical device inventories at a local level, service labels were affixed to equipment to ensure staff informed them when equipment needed to be serviced.

Patients could reach call bells and staff responded quickly when called. All patients had access to call bells which were located by their beds. Staff would check during comfort assessments that patients could access their call bell. On most wards we observed that staff responded quickly when patients used the call bell.

Staff disposed of clinical waste safely. Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately, clinical waste bins were clearly labelled. We observed staff keep the rooms used to store clinical waste clean and tidy, to minimise infection risk.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Most staff identified when patients were at risk of deterioration, however, we were not assured there was always timely action taken.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of National Early Warning Scores (NEWS2).

Staff on wards used a portable handheld device where they could record patients' NEWS2 and observations. Observations were assessed and scored automatically which removed the chance of human error. The information was accessed and monitored by medical staff. Staff also had access to a critical care outreach team who could be bleeped for an urgent review of deteriorating patients.

Audits of NEWS2 across the wards for the period of June to September 2023 showed documentation was not completed consistently with 5 of the 6 wards not always meeting the monthly target of 90%.

The sepsis care bundle tool kit was used for the diagnosis and treatment of patients with suspected sepsis to enable consistent and timely treatment. Data provided by the trust showed that the sepsis care bundle was not always implemented appropriately for deteriorating patients. In the period July to September 2023 compliance across the 7 wards was between 72% and 84% for observations completed within the recommended frequency intervals, and between 78% and 85% for documented evidence the NEWS2 had been acknowledged and escalated in line with trust policy. This was below the trusts target of 90%.

Staff did not always complete risk assessments for each patient on admission or review these regularly. The service used the aSSKINg care bundle which stands for 'assess risk; skin assessment and skin care; surface selection; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help' and is a tool which ensures all fundamental aspects of pressure ulcer prevention are included in patient care. We saw evidence in patient notes that risk assessments had been completed. However, data provided by the trust for the period April to September 2023 showed these were not always completed consistently for all patients. For example, for patient’s skin integrity being assessed within 6 hours of admission or if transferred to the ward overnight by 11am the following day, the wards did meet the trust target of 90% for the 6 month period April to September 2023; but where a skin chart was in place data showed the log had not been completed daily for the past 5 days, wards scored between 82% and 93% for the same 6 month period.

Data provided showed patients’ nutrition was not always assessed within 6 hours of admission or if transferred to the ward overnight by 11am the following day, with wards scoring between 68% and 87% for the completion of the Malnutrition Universal Screening Tool (MUST). The number of patients who had their MUST reassessed at least weekly, was between 72% and 83%.

Data provided also showed the number of patients who had a falls risk assessment within 6 hours of admission or if transfer to the ward overnight by 11am the following day exceeded the trust target of 90% and the number of patients

who were reassessed at least weekly scored between 86% and 100%. The trust had an overarching action plan for falls in place since November 2020, the action plan had 13 actions in progress which was last updated in September 2023; 36 actions had been completed. One of the actions included fall's training for all staff in adult inpatient areas, data showed that as of September 2023 92% of staff had completed the training.

Doctors we spoke with told us requesting and accessing patient investigation results electronically was problematic as they felt the system had poor functionality and was slow which caused unnecessary delays when requesting diagnostics, such as blood tests and scans. One consultant told us they would often have result to paper-based requests which resulted in a lot of duplication in their work. Doctors felt the IT system did not help to make their tasks easier. Following the inspection, the Trust advised they have plans to implement a replacement electronic communication and results reporting (OCRR) solution, this will commence in June 2024 after the Trust has implemented Careflow PAS and ED in April 2024. This is also being implemented in partner organisations which will result in improved speed and visibility of diagnostics across organisations. It will also facilitate the removal of paper based radiology forms.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed board rounds between nursing, medical and therapy staff. Staff involved were given a written handover document which summarised key information about each patient in a situation, background, assessment, recommendation (SBAR) format. SBAR is a recognised tool for structured communication of critical information.

White boards were used at to indicate for example if patients were at risk of falls, on a special diet or fluids, needed assistance with moving, or needed pressure ulcer care. This ensured all staff were aware of key risks for patients.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff an induction.

The trust used a safer staffing tool to plan the numbers of staff needed on each ward in relation to the needs of the patients on each ward. Planned and actual staff numbers for nurses and care staff were displayed on wards. If wards had concerns these would be escalated.

The number of nurses and health care assistants did not always match the planned numbers. During the inspection, the planned and actual staffing levels varied depending on the shift. For example, we found that the early and late shifts were short by 1 nurse and night shift were as planned on 3 of the wards. Staff we spoke with reported that the staffing levels had improved and there was less reliance on agency staff. Senior managers reported that international recruitment had been successful. Recruitment was identified on the divisional risk register.

Data provided by the trust showed the current nursing establishment budget for September 2023 was 326.51 whole time equivalent (WTE) and the total WTE worked was 397, which represented an over budget of 70.49 WTE in the nursing establishment.

Ward managers reported they tried to cover vacant shifts with their own staff as bank staff. The use of bank and agency staff across the wards varied. Data provided for the last 6 months showed that the use of bank on the wards varied from 7% to 22%, with 2 out of 11 wards exceeding the trust target of 20% for use of bank. The use of agency staff for the same 6 month period was between 3% to 25%. The use of agency on 7 wards exceeded the trust target of 9%. Agency staff we spoke with told us they had received an induction when they started on the ward.

Medical care (including older people's care)

Ward 21 at the Royal Shrewsbury Hospital was being used as an escalation ward, staff told us the ward had been open for about 4 weeks prior to our visit. As the ward was temporary, there were no substantive staff working full time on the ward, with staff being moved from other areas. Data provided by the trust showed us the ward was staffed by 35% bank staff, 60% agency staff and 5% substantive staff. During the time the ward had been opened, there were no substantive staff working on the ward for a total of 11 days. Staff we spoke with told us nursing staff were pulled from other wards. On the day we visited the ward, 1 member of staff we spoke with was on the ward for the first time and was not sure who to ask for support.

The service had low turnover rates. During the period April to September 2023 staff turnover was an average of 2% per month.

The service had low sickness rates. During the period April to September 2023 staff sickness was an average of 5% per month.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service always had a consultant on call during evenings, overnight and weekends. Consultants led daily ward rounds on all wards Monday to Friday and on some speciality wards at the weekend. There was also a discharge consultant that worked from 9am to 1.30pm on Saturdays and Sundays. Junior doctors worked across the wards Monday to Friday from 9am to 5pm and could be contacted via a bleep to support the wards at night.

Medical staff told us they had support and access to consultants, the rota worked well with nights rotated and they did not work over their hours very often. Nursing staff told us that the doctors were easily contactable, and they covered 2 or 3 wards.

Data provided by the trust showed the current medical staffing establishment budget for September 2023 was 39.03 WTE and the total WTE worked was 76.18, which represented an over budget of 37.15 WTE.

Agency doctors were mostly locum posts that covered the wards. The average number of agency consultants booked over each the month based on 40 hours per week providing WTE numbers was between 11.15 WTE and 14.43 WTE per month and consultants who worked on the bank was between 4.61 WTE and 8.65 WTE. The average number of agency junior doctors booked over each the month based on 40 hours per week providing WTE numbers was between 24.7 WTE and 34.5 WTE per month and junior doctors who worked on the bank was between 9.01 WTE and 16.81 WTE. Mainly foundation year 2, specialist trainee year 1 or 2 or equivalent doctors worked as bank or agency staff.

Managers made sure locums had a full induction to the service before they started work. Medical staff who worked as locums told us they had a full induction before they worked on the wards. Most of the doctors we spoke with had been working at the trust for at least 12 months. Senior medical staff advised that they were looking to make permanent roles to move away from locum posts working 9am to 5pm.

Doctors in training felt consultants were approachable and they felt supported. Teaching sessions for doctors included attendance at ward and board rounds. The junior doctor rota included dedicated teaching slots for junior doctors.

Medical care (including older people's care)

The service had low and/or reducing turnover rates for medical staff. During the period April to September 2023, staff turnover was an average of 5% per month.

The service had low sickness rates. During the period April to September 2023, staff sickness was an average of 3.64% per month.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.

The hospital used paper patient records to record patient needs, care plans and risk assessments. We looked at 16 records and found care plans were in place and there was evidence these were reviewed daily. We saw NEWS2 observations and venous thromboembolism risk assessments had been completed. Sepsis bundles were completed where appropriate. The records also included evidence of the daily ward round review. Allergies were also recorded on drugs charts.

Records were mostly kept securely in locked trolleys close to the nurses' station. Records were multidisciplinary; therapy staff documented findings in the medical records. Nursing and medical records were kept together in the records trolleys. This meant that all staff were able to access all patient records when required.

Staff also used an electronic patient record (EPR) to record patients' observations which updated the NEWS2. The electronic system allowed early warning scores to be automatically calculated within the EPR and push real time alerts for deteriorating patients with a known infection. The EPR records were electronically signed, with time and date of the entry which meant it was clear who had updated the record. Staff had secure access to the EPR. This meant that patient information and records were stored securely.

Staff told us that matrons and ward managers reviewed records monthly, and the nurse in charge would review 5 records per shift to identify any gaps and prompt improvement.

All the wards had electronic whiteboards displayed in areas where patients and visitors could see them. The whiteboards detailed the patients full name, surname, and bed number so they could be easily identified. However, this did not respect patient's privacy or keep patient's information confidential.

Staff used whiteboards to document a patient's journey through the ward and were updated during each shift. The white boards included information such as risk of falls, if they were living with dementia, had pressure areas or needed assistance at mealtimes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff completed medicines records accurately and kept them up to date. We checked 16 prescription charts and saw that information on patient demographics and allergy statuses were complete.

Nursing documentation audits were undertaken across the wards monthly, and included checking patients had a prescription chart with drugs prescribed, the chart had recorded the patients name, date of birth, hospital number, allergy status and if the chart was legible. Data provided showed for the 3 month period July to September 2023,

compliance was between 99% and 100%. The nursing documentation audits also checked if the transdermal patches record was attached to the drugs chart, data provided showed compliance varied and was between 42% and 100%. However, where the record was in place, data provided showed compliance was 100% over the 3 month period for the record being completed correctly.

Staff stored and managed all medicines safely. Medicines were generally stored securely. Treatment rooms where medicines were stored were visibly clean and tidy. The nurse in charge held the key to the treatment room. A random selection of medicines was checked across the wards and these were all in date. Pharmacy staff visited wards and conducted medicines reconciliation. (Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct).

Safe and secure handling of medicines audits were undertaken regularly. The data provided highlighted the main issue across the wards was the unsafe security and storage of medicines. Where this had been identified an action plan had been put in place with target dates for completion.

Room temperatures and fridge temperatures of treatment rooms were recorded daily. We checked the medicines fridge temperatures and ambient room temperature and found them to be within expected range.

Nursing staff we spoke with were aware of the policies on the administration of controlled drugs (CDs). CDs were stored in line with required legislation and recorded in a CDs logbook. We viewed the logbook where staff recorded when CDs had been used and stock was checked. Two members of staff checked the CD stock levels. We checked a sample of these and found them to be accurate and the medicine in date.

Staff told us that medicines to take home (TTO) were not always dispensed in enough time to prevent delays in patients being discharged. However, pharmacists we spoke with told us they were not always advised of patients for discharge with enough notice leading to delays when prescriptions were not completed before the discharge letters were completed. Pharmacist staff advised they also assist the dispensing team for set sessions on a weekly basis. This enabled them to keep their dispensing skills up to date. We did not observe TTO delays during our inspection and the trust did not improve details of incidents reported regarding TTO delays.

Sepsis trolleys or boxes were available for the immediate treatment of sepsis on the wards. These were checked daily to ensure the medicines were available and in date and therefore, safe to use. This helped to ensure that staff could follow the National Institute for Health and Care Excellence guidance which states patients should receive intravenous antibiotics within 60 minutes.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff we spoke with were aware of how to report incidents and knew how to raise concerns using the trust electronic incident reporting system, widely used in the NHS to report incidents including near misses. Staff reported an open culture, and they were encouraged to report incidents and received feedback. Nursing staff told us there was a focus on learning from incidents. Managers investigated incidents and shared lessons learned and feedback at team meetings. A sample of minutes of team meetings from across the ward’s showed incidents were discussed and leaning identified including action to be taken where required.

Medical care (including older people's care)

In the 12 month period October 2022 to September 2023 a total of 2,754 incidents were reported. 98% of were reported as no harm or low harm, 26 incidents of moderate harm, 5 incidents of severe ham, and 3 were deaths. Information provided by the trust did not provide a breakdown of the themes.

The trust reported 1 never event in medical care in the last 12 months which was currently undergoing investigation. 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.

Staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation when things went wrong. Staff we spoke with were able to explain the duty of candour. We saw investigations from incidents where the service had applied the 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.

The learning from deaths group met monthly to review all deaths across the trust. We reviewed 3 sets of minutes and saw minutes included an action log review, learning from deaths, and themes and trends from across the divisions.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the hospital intranet. These included the National Institute for Health and Care Excellence (NICE) guidelines.

We reviewed a sample of hospital policies and standard operating procedures (SOP) including policies for safeguarding adults at risk, infection prevention and control, medicines code, adult sepsis recognition and management SOP, and the early warning scores policy. These were all in date and appropriately referenced national guidance and best practice, such as that recommended by the NICE.

The service had an audit programme. In the 12 month period from October 2022 to September 2023, 22 local and national audits had been completed with a further 23 in progress. The completed audits were RAG (red, amber, green) for compliance against the SOP. Where compliance was below 80%, action plans were in place to address the issues identified. Audits included think glucose, pneumonia (hospital-acquired) antimicrobial prescribing, and older people with social care needs and multiple long term conditions.

Medical care (including older people's care)

Care pathways were based on national guidance for conditions, such as sepsis and pressure ulcers. Patient risk assessments used by staff were based on national tools, such as the Malnutrition Universal Screening Tool (MUST), the National Early Warning Scores 2.

Nursing documentation audits were undertaken monthly across all the medical wards these included ensuring there was a clear plan of care documented in the last 24 hours, ensuring the patient had been assessed using the MUST on admission/transfer to the ward within 6 hours or if overnight transfer by 11am the following day and patients' height and weight had been recorded within the 6 hours of admission to the ward.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs. However, the completion of nutrition and fluid balance charts was below the trust target of 90%.

Staff completed patients' fluid and nutrition charts where needed. On review of the data from the nutrition audits for the 6 month period April to September 2023, compliance showed that completion of the nutrition assessment had improved from our inspection in November 2021. The completion of nutritional risk assessment tools had increased from 79% to 81%. However, this was below the trust target of 90%.

Data from the audit results from the inpatient wards for the 3 month period June to August 2023 showed the fluid balance chart completion had increased from 72% to 83%. This was below the trust target of 90%. Intravenous fluids were prescribed when required. Fluid balance charts were used to monitor patient's hydration status.

Specialist support from staff, such as dietitians and speech and language therapists were available for patients who needed it. Dietetic and speech and language therapy services worked closely with nursing and medical staff in assessing and supporting patients with eating, drinking and swallowing needs.

Patients were given meal choices and hot drinks were offered in between meals. Drinks were left within reach, and patients were given assistance to drink if required. We observed staff providing patients with a menu and supported them to make appropriate meal choices. Patients with special nutritional needs were identified to the ward hostess and appropriate food choices were overseen by the ward manager for those patients on special diets. Above patient beds icons on boards indicated if they had any special nutritional requirements.

Special diets to meet patients cultural and religious needs were available. Soft and pureed diets were offered to those patients with swallowing difficulties where appropriate. Staff were observed providing support to patients at mealtimes.

Patients we spoke with told us they were generally happy with the food. The trusts local inpatient survey for the 12 month period April 2022 to May 2023 covered the acute wards across the trust. The trust scored 57% for patients being offered a choice of food and 83% for patients receiving enough help from staff to eat their meals.

The trusts nutrition and hydration steering group met monthly which focused on for example, staff education, training and nutrition related incidents. The trust advised the dietetic and speech and language teams were due to provide a series of half day study sessions from October 2023 across the hospital for staff**.** The quality team were continuing to support the wards with MUST training, and nutrition and hydration were on the program agenda for the quality team study days which take place twice yearly.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool. We saw in records that patients had been prescribed and administered pain relief and this had been recorded. Patients' pain was assessed as part of the wards regular comfort assessments completed on all the wards and their score was recorded on the patient clinical monitoring system.

The monitoring system alerted staff if the patient's vital signs were outside acceptable limits. The service had access to alternative pain tools for patients with communication needs. Patient comfort assessments are a structured means of promoting patient centred care which focused upon patients' pain, positioning and personal care needs. Staff told us that they used the Abbey pain scale as a method for identifying the signs of pain in people with communication difficulties, for example, those living with dementia. However, we did not see this in use in the records that we reviewed.

Patients received pain relief soon after requesting it. Most patients we spoke with told us their pain had been managed appropriately and they generally received pain relief in a timely manner; however, 1 patient out of 15 patients spoken with told us they had requested pain relief but had to wait a while before it was administered.

Staff had access to the pain management team for advice.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. These included the national Commissioning for Quality and Innovation (CQUIN) for appropriate treatment of community acquired pneumonia, the national audit of dementia care in general hospitals and the 2022 audit of blood sample collection and labelling. Data provided for the national CQUIN for appropriate treatment of community acquired pneumonia, April to June 2022 showed compliance was 7% which was below the CQUIN threshold as 45% to 70%. CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care.

For the national audit of dementia care in general hospital round 5 published in August 2023, data was collected between September 2022 and January 2023. The national audit showed for the 7 key metrics assessed the hospital was similar to the national performance for pain assessment (98%) and pain reassessment (100%) and lower that than the national performance for delirium screening (83%), pain tool (46%), initial discharge plan in 24 hours (25%), carer overall care quality (61%) and carer rating for communication (58%).

The hospital had a dementia friendly hospital charter action plan June 2021 to June 2024 in place. Data provided showed that 56 action were in place, 51 were in progress and RAG (red, amber, green) rated as green with 18 of the actions completed.

The 2022 audit of blood sample collection and labelling undertaken in October 2022. The national audit showed scored between 99% and 100% in 4 of the 5 standards. No data was provided for the 5th standard.

Medical care (including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These included local audits of documentation for nutrition, dementia, falls, venous thromboembolism, and renal dialysis. We saw actions and learning from the local audits were disseminated in some ward team meetings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nursing shifts were covered by registered nurses, nursing associates and health care assistants and were supported by a senior nurse who was in charge of the ward.

Nursing staff told us they were supported with their revalidation. Revalidation was introduced by the Nursing and Midwifery Council in 2016 and is the process nurses must follow every three years to maintain their registration.

Staff had access to practice education facilitators to support staff with training and skills development. For example, health care assistants were being trained in patient cannulation and senior nurses were being trained in level 1 enhanced skills.

Newly qualified nurses were supported to complete preceptorship training. Preceptorship is a period of time to guide and support all newly qualified practitioners to translate their knowledge into everyday practice and make the transition from students to develop their practice further. International nurses were supported to complete their objective structured clinical examinations (OSCE) to become registered with the Nursing and Midwifery Council.

On rotas we saw that junior doctors had regular half day teaching sessions were included in their working rotas as protected time. However, feedback received from some junior doctors was that some areas were better than others when releasing staff for training.

Managers gave all new staff an induction tailored to their role before they started work. An international nurse told us they worked supernumerary to planned nurse staffing numbers until they had completed their OSCE. Agency nurses we spoke with told us that they had an induction to the ward.

The hospital had a team of 44 clinical nurse specialists specialising in, for example, care of the elderly, dermatology, endocrinology, general medicine, renal, respiratory and lung.

Managers supported most staff to develop through yearly appraisals of their work. Staff we spoke with told us they had received appraisals. Data provided by the trust demonstrated that 79% of nursing staff had received an appraisal in the last year and 94% of medical staff had received an annual appraisal in the last year. This was an overall compliance rate of 80%.

Managers did not make sure staff attended team meetings, however, staff had access to meeting notes when they could not attend. Staff meetings were in place on most wards, however, were held at different frequencies (monthly, bimonthly or quarterly). The meetings were documented, most wards followed a standard agenda and meeting template. Minutes were circulated via email.

Medical care (including older people's care)

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was effective multidisciplinary team (MDT) working in the ward areas. Relevant professionals were involved in the assessment, planning and delivery of patient care.

Patients had their care pathways reviewed by the relevant consultants. Consultant led multidisciplinary board rounds took place daily, Monday to Friday on the wards and 7 day ward rounds were in place on the specialty wards.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw that MDT working was evident on the wards; physiotherapists, occupational therapists, patient flow coordinators and pharmacists were part of ward rounds. Staff we spoke with felt the team worked well.

There was evidence of an MDT approach to discharge planning with patient flow coordinators on the wards to facilitate social care packages for patients on discharge.

Ward and specialist medical teams had access to the full range of allied health professionals and nurse specialists, such as speech and language therapists, occupational therapist, dietitians, dementia specialist, tissue viability, and diabetic nurses.

Records confirmed involvement from healthcare professionals of different disciplines, where appropriate. For example, patient records showed the involvement of occupational therapists, speech and language therapists, physiotherapists and dietitians, as well as appropriate referrals to specialist nurses or teams.

Staff had access to the mental health liaison team who supported staff to provide appropriate care for patients experiencing mental ill health. Staff were able to contact the team 24 hours a day for specialist assessment of patients with complex mental health needs. The service also had access to a specialist dementia nurse who worked across the wards.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Consultants led daily ward rounds on all wards Monday to Friday and on some speciality wards at the weekend. Staff told us the hospital was not resourced or funded for 7 days working. Cover out of hours and weekends was provided by senior and junior doctors. Consultants were available on call. At the weekends a discharge consultant covered the wards from 9am to 1pm.

Clinical nurse specialist mostly worked Monday to Friday. However, staff on the renal unit worked Monday to Saturday and provided a 24 hours a day 7 days a week on call for acute or emergency patients. The continuous ambulatory peritoneal dialysis (CAPD) team provided a 7 day a week cover from 7am to 5.30pm. The trust advised a business case was in progress for 7 day working for specialist endocrinology nurses.

Physiotherapists provided respiratory assessment and treatment at weekends from 8.30am to 4.30pm, and an out of hours on call emergency respiratory physiotherapy service for any patients who requires emergency intervention from

4.30pm to 8.30am 7 days a week. To help facilitate patient discharges at the weekend a physiotherapist, occupational therapist, and a therapy support worker was available for all specialities from 8.30am to 4.30pm to focus on same day discharges or reducing patients' length of stay. The physiotherapist time was split to include 4 hours per day dedicated to the assessment and treatment of patients following a fractured neck of femur.

Pharmacy services were available from 9am to 5.30pm Monday to Friday. A clinical pharmacy and dispensary supply service was also provided on Saturdays from 9am to 4pm and in the morning on a bank holiday. An on-call pharmacist service was available outside of pharmacy hours to provide medicines advice and supply of emergency medications to inpatients.

The pathology service was available 24 hours a day, 7 days a week for acute work including biochemistry, transfusion, and haematology. Microbiology was available on-call out of hours.

Some radiology services were available 24 hours a day, 7 days a week, these included Computerised Axial Tomography (CT) X-ray. Magnetic Resonance Imaging (MRI) and Ultrasound.

Mental health liaison services and specialist mental health support were available 24 hours a day, 7 days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw some wards had relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff identified patients who needed additional support and had long term conditions. Patients were assessed by specialist teams including occupational therapy and physiotherapy services, and the dietetics team.

Patients who were identified as being at risk of a fall, were given information about prevention of falls within hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, nursing staff training was below the trust target of 90%.

Nursing staff received and kept up to date with training in the Mental Capacity Act (MCA) and DoLS. Data provided by the trust showed 80% of staff had received training in the Mental Capacity Act and DoLS. This was below the trust target of 90%.

Doctors received and kept up to date with training in the MCA and DoLS. Data provided by the trust showed 92% of staff had received training in the MCA and DoLS.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us they always asked a patient before they provided any care, where patients had capacity, they would seek verbal consent. Doctors would obtain consent from patients who were undergoing procedures. The trust had a consent to examination and treatment policy.

Staff recorded consent in the patients' records. We observed nursing staff asking patients for verbal consent to provide care or treatment, where they were able to provide this. When patients could not give consent, staff made decisions in their best interest. In records we reviewed for patients who were under a DoLS application the mental capacity assessments and best interest decision had been completed, this was also documented on nurse handover sheets which meant all staff would be aware.

Managers monitored the use of DoLS and made sure staff knew how to complete them. In nursing documentation audits for July to September 2023, the wards scored between 88% and 92% for documentation of evidence of a completed mental capacity assessment being completed correctly, and 100% for all DoLS documentation.

Is the service caring?

Good

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were generally discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw a caring approach from staff. We saw that staff talked to patients in a friendly and reassuring manner.

Patients said staff treated them well and with kindness. We spoke with 15 patients and relatives; they were mostly positive about the care they received. Most of the patients we spoke with were positive about the care and treatment provided. They told us the nurses were very good, kind and caring. Patients told us their dignity and privacy were respected, for example, staff drew the curtains to speak to them privately or when assisting with personnel care. Patients commented, "The staff are really nice and really friendly. Nothing is too much trouble for them', 'The staff are excellent. If anything personal needs doing, you only have to ask'.

However, 2 families we spoke with raised concerns about the care their loved ones had received. One relative told us their relative had been moved to another ward where there was not enough staff, their catheter had not been emptied, no drinking water was available and there had been no arrangements for lunch. They told us they had requested a meeting about the move, but this did not happen. Another relative we spoke with told us they had made 3 complaints about the care their loved one received, which were being investigated.

The hospital monitored the Friends and Family Test survey monthly; however, we found the results were not displayed on the acute wards. From April to September 2023, the responses received by the trust was 9% (1,859) with 97% (1,806) patients rating their experience of the service as very good or good.

The trusts local inpatient survey from April 2022 to May 2023 covered all the acute wards across the trust. The trust scored 82% for staff treating patients with dignity and respect and 83% for staff being caring and compassionate.

Medical care (including older people's care)

On some medical wards, we observed thank you cards from patients, relatives and carers which were on display. There were messages thanking staff for their caring and kindness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff on most of the wards inspected as part of the inspection gave patients and those close to them help, emotional support and advice when they needed it. However, on the acute medical unit and acute medical assessment patients told us nursing staff were very busy. During the inspection we did observe nursing staff were not always available to respond to patients' needs; however, staff did appear to make patient care a priority over other tasks. For example, we observed 1 member of staff stopping what they were doing when they saw a patient needed assistance with dressing. We also noted that a consultant requested the mother of a patient who had been sitting on a chair all night be found be something more comfortable to sit on.

Staff were able to request enhanced care support or one to one care for patients who required enhanced care support. The additional staffing to support these patients ensured care was safe and was approved daily for patients. This meant that staff were able to focus care and attention on these patients and meet their needs. In patient records we saw where documentation had been completed. Records also recorded where this had not been available.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Relatives and carers were able to visit outside of visiting times on the care of the elderly and some of the specialist wards.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Chaplain support was available 24 hours a day 7 days per week. The chaplaincy team were from a range of faiths and beliefs. The chapel was open 24 hours a day, every week. Chaplaincy services were available to patients at their bedside for those who were unable to attend chapel.

The trusts local inpatient survey for the 12 month period April 2022 to May 2023 covered the acute wards across the trust. The trust scored 47% for being able to talk to staff about their worries and fears.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff involved patients in decisions about their care and treatment. Most patients and relatives we spoke with said they understood their care and treatment and staff took time to explain their plan of care. One relative told us that information was given in a way they could understand.

Staff supported patients to make advanced decisions about their care. We saw Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were completed in patient records where appropriate. The ReSPECT process supports patients to identify their care and treatment wishes for the future in a situation where they may be unable to make or express choices. We saw that these choices were made through conversation between patients, their families, and staff. In nursing documentation audits for July to September 2023, the wards scored between 92% and 97% for documentation of evidence of communication with patient and or family in the patients notes.

Medical care (including older people's care)

Following the inspection, the hospital provided examples of patients' journeys. One example provided was for a patient who was receiving end of life care. The family were provided with a reclining seat and mats to sleep in so that 2 family members could stay with the patient, so they were not alone. The family commented that the care and compassion that their relative was shown was above and beyond their expectation

The hospital gathered patient feedback on several aspects of care throughout the patient journey. In the 3 month period July to September 2023, results were consistently between 97% and 100% for the questions: 'When doctors speak about your care in front of you, are you included in the conversation and when you ask doctors questions, do you get answers you can understand.

Is the service responsive?

Requires Improvement

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

Service planning and delivery to meet the needs of the local people.

The service did not always provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The acute medical floor planned the services, where possible, to avoid long hospital admissions. The service had been refurbished to provide an acute medical assessment (AMA) area for patient's initial assessments. This was a seated area with 12 reclining chairs but could take up to 15 and 3 bays for trolleys. The acute medical unit (AMU) was for short stays between 24 to 48 hours, however during the inspection we observed patients were staying longer. Patients requiring a longer stay would be admitted to ward 22 short stay for between 3 and 4 days. The acute medical floor held twice daily multidisciplinary team meetings to review patients' treatment plans. The acute medical floor bed meeting was held once a day Monday to Friday and included discussions concerning delays and discharge. The acute medical floor worked closely with the speciality wards and patients who required longer stays would be admitted to the speciality wards. At the time of the inspection one of the patients we spoke with had been on the AMU for 6 days.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care unit (SDEC) was part of the acute medicine and located next to the emergency department. The SDEC provided care and treatment to patients who did not require an overnight stay who were referred by patients' general practitioners (GP's), the emergency department or for a follow up appointment. The unit was open from 8am to 8pm for admissions 7 days a week, with the last patient leaving by 10pm.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All the wards visited during the inspection had single sex bays. The trust reported no mixed sex breached on the wards across the medicine service in the 6 month period April to September 2023.

The service had systems to help care for patients in need of additional support or specialist intervention. Above patient beds boards were used to identify patients who required additional support or special care requirements. These symbols were also used on the patient status board which was located at the ward nursing station. Symbols were used to identify if patients had dementia, were at risk of falls or required support from specialist nurses or therapy staff.

Medical care (including older people's care)

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The trust used a software programme to record patient demographics. There was a flag system which enabled a range of demographic data to be flagged, such as vision impairment and interpreter required. The system also alerted specialist nurses, such as the dementia specialist nurse and acute liaison nurses, to identify patients who had been admitted and to access early support.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were specialist teams to support patients with mental health problems, learning disabilities and dementia. These teams visited the medical wards regularly to provide advice and support.

The trust advised Learning Disability Guidelines were developed in partnership with another provider who were commissioned to provide the acute liaison nurse (ALN) service. The completion of patient passports was supported by clinical staff or the ALNs. We saw one hospital passport was in place in the records we reviewed.

The wards were not designed to meet the needs of patients living with dementia. However, most wards had some adaptations to make them more dementia friendly for example signage and visible large face clocks.

The service used a butterfly icon on boards above patients’ beds to identify any patients with dementia. Data provided showed for the 3 month period July to September 2023 compliance was between 75% and 100% for the butterfly scheme been instigated appropriately and between 83% and 100% for referring the patient to the dementia team.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw food menus and saw that there was a range of choices for patients with healthier choice, vegetarian, gluten free, food intolerances or allergies. The staff provided support with meals as needed. Hot and cold drinks, and snacks were readily available and within easy reach for patients. Patients we spoke with were generally happy with the choices they had been offered.

The trust advised interpretation and translation were available for people accessing services who communicated through British Sign Language or needed an interpreter or translation services. Staff were able to access the interpreting services via the trust intranet. Makaton healthcare cards were also available on wards to support communication; although, these were not seen in use during the inspection.

The hospital had a multi-faith room. The hospital chaplaincy service was multi-faith and provided spiritual support 24 hours a day, 7 days a week. Staff were aware of how to contact chaplaincy services for patients and their families.

Nursing staff received training in the dementia awareness and learning disabilities. Data provided showed 94% completed level 1 dementia awareness, 91% had completed level 2 dementia awareness training and 86% had completed learning disabilities. The trust had recently introduced Oliva McGowan learning disability and autism training; 60% of nursing staff had completed the training at the time of the inspection.

Medical staff received training in the dementia awareness. Data provided showed 72% of medical staff had completed level 2 training which was below the trust target of 90%.

Medical care (including older people's care)

Access and flow

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

Managers monitored waiting times but were not always able to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. Trust wide data provided for the percentage of complete admitted referrals to treatment pathways where the patient had been waiting more than 18 weeks was 51% (489) The percentage of patients waiting more than 52 weeks was 29% (278).

Trust wide data provided for the percentage of incomplete admitted referrals to treatment pathways where the patient had been waiting more than 18 weeks was 67% (5,692) The percentage of patients waiting more than 52 weeks was 14% (824).

Managers and staff were not always able to make sure patients did not stay longer than they needed to. Hospital wide data showed the average length of stay in the 12-month period 1 September 2022 and 30 September 2023, was between 9.5 days and 13.9 days for both elective and non-elective admissions. This was higher than the than the expected England average.

Managers monitored the number of patients whose discharge was delayed. The trust advised there was a total of 1,521 patients whose discharge was delayed following the decision to discharge them in the 6 month period April to September 2023. This was split between general medicine 66% (1,011), geriatric medicine 9% (150) and respiratory medicine (150).

The hospital had 2 escalation wards (ward 21 and ward 18) in operation at the time of the inspection where patients would be moved to if they were medically fit for discharge. Nursing staff told us that consultants attended the wards daily to review the patients and if patients had deteriorated, they would be transferred to an acute ward. The trust had a standard operating procedure (SOP) for the criteria for transfer of medical fit patients to ward 21 escalation ward at Royal Shrewsbury Hospital.

Managers and staff started planning each patient's discharge as early as possible. Patient flow coordinators worked across the wards to help facilitate patients discharge. We observed a deep dive with a matron, ward manager and patient flow coordinator who were reviewing patients notes to see what tasks, such as bloods, referrals to other services and medication needed to be undertaken to help facilitate discharge. The nurse responsible for the bay would also attend the meeting. The information was added to the discharge board, so all staff were aware. GPs were able to admit patients directly to the acute medical assessment area, these patients would have previously gone to the emergency department (ED). This change reduced patients' length of stay and reduced the number of patients arriving at ED.

The hospital's discharge lounge had 2 side rooms and a seated area. The lounge opened from 8am to 8pm Monday to Friday; by moving patients to the discharge lounge whilst patients waited for medications, discharge letters and hospital transport, the trust created capacity on the wards for patients with a decision to admit from the acute medicine floor and ED. However, staff advised the discharge lounge was used to accommodate patients overnight as an overnight overflow area for ED up to 2 to 3 times a week, which caused delays in opening the lounge as beds needed to be moved and the area cleaned. This was in line with the trusts escalation of the discharge lounge standard operating procedure (SOP) which was provided by the trust following the inspection.

Medical care (including older people's care)

The urgent emergency care improvement programme 2023/24 was looking at how the trust could deliver continuous improvements in patient flow that were sustainable. There were 12 work streams that had been identified which included improving discharge. The plans included increasing the number of patients transferred to the discharge lounge and to increase the number of patients in the discharge lounge to 10 by 10am, by the end of June 2023. The target was to have 30 patients discharged from the discharge lounge by the end of September 2023. No information was provided to demonstrate if these targets had been met.

Staff did move patients between wards at night. Data provided by the trust showed that there was a total of 6,226 bed moves out of hours across the trust in the 6 month period April to October 2023. Site specific information was requested but this was not provided. Out of hours ward moves were after 9pm and before 7am. The trust advised they had recently started to monitor the number of bed moves especially at those at night.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Nursing staff we spoke with explained medical staff would regularly review patients as part of their ward rounds. In the 6 month period April and September 2023 a total of 113 patients were placed on wards that did not match their care group. The trust advised some of the wards had local acceptance criteria for the acuity and type of patient they were able to receive but there were no current overarching medical outliers' criteria.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff understood the policy on complaints and knew how to handle them. The trust had an up to date concerns and complaints policy and procedure which was available on the trust intranet. Most staff were aware of the trust's complaints policy and of their responsibilities within the complaints process. Staff told us if patients complained they would try to resolve it at the time or direct them to Patient Advice and Liaison Service (PALS). Formal complaints were directed to the trust's complaints department.

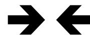
The service displayed information about how to raise a concern in patient areas. Information was available on the wards about the PALS. Patients were able to leave comments, raise a concern or complaint via the trust website.

Managers investigated complaints and identified themes. Managers were responsible for investigating complaints relevant to their clinical area. The latest PALS, complaints and patient experience quarterly report for April to June 2023 showed that the trust received a total of 231 complaints, which equated to 0.89 in every 1,000 patients complaining. Of the 217 complaints closed during the period April to June 2023, 10% (23) were not upheld, 67% (145) were partly upheld and 23% (49) were fully upheld. There were 170 complaints in progress in the medicine and emergency division identified in the quarterly report. Of these, 67 were cases still open and the responses from the trust were overdue. Key themes included communication, clinical treatment, patient care, admission and discharge, staff values and behaviours.

Managers shared feedback from complaints with staff and learning was used to improve the service. The quarterly PALS, complaints and patient experience reports identified any learning from complaints investigations and actions that had been taken as a result. Managers told us that complaints were discussed at daily safety huddles and in team meetings. In nursing team minutes reviewed we saw that feedback from complaints was part of the agenda with learning identified.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

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

Leadership

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

There was a clear leadership structure with defined lines of responsibility and accountability. The medical care core service was part of the medicine and emergency care division. The division was led by a triumvirate which was made up of the divisional medical director who led the medical team, the divisional director of nursing who was responsible for the nurses and the divisional director of operations .

The Leadership team had a comprehensive understanding of challenges and had a good grasp of the priorities of the medical care services, such as recruitment, staff retention and capacity and flow issues across the hospital.

Day to day leadership was managed by the matron and ward managers. Staff told us the ward managers were supportive and matrons were visible and supportive. Most staff we spoke with knew the names of the senior leadership team and told us that senior leaders regularly visited the wards.

Senior nursing staff we spoke with told us there was more stability within the trust executive team and better communication. For example, weekly video meetings had been set up with senior staff so there was an opportunity to share work related concerns and issues. They also told us they no longer felt isolated and were better informed about what was happening within the trust.

Staff told us there was good teamwork and support within medical services. Staff told us they were supported by their managers to develop their skills, access development opportunities, and take on more senior roles. For example, a health care assistant (HCA) through the trainee nursing associate programme qualified as registered nurse was working in the acute services as a band 5 nurse, new HCAs complete an initial 2 week training period and international nurses were required to complete a 12 week training programme to complete all their mandatory training and competencies before they began working on the wards.

Vision and Strategy

The service had a vision for what it wanted to achieve; however, capacity, flow and discharges in the department was challenging. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The vision and strategy for the medicine and emergency care division reflected the hospitals mission and values. Staff we spoke with knew about the hospital's mission statement 'To provide excellent care for the communities we service'.

Medical care (including older people's care)

We saw the hospital's values ‘Partnering, Ambitious, Caring and Trusted’ were displayed around the hospital. Most staff we spoke with knew and understood the trust's vision, values and strategy and their role in achieving them. The vision, values and strategy had been developed in collaboration with staff, and staff were able to keep up to date with progress through the trust intranet, regular bulletins and through visual displays across the trust. Staff were committed to providing safe care and improving patient's experience.

The divisional strategy’s main focus was on flow improvement across the hospital to improve the patient experience. The division had 4 workstreams focusing on different areas to improving discharges, which included increasing the numbers of patients utilising the discharge lounge early in the days to create early flow, reducing patients’ length of stay by reviewing process on the wards, improving the discharge processes to support earlier in the day discharges and reduce incomplete discharges, and referring patients to therapies earlier for assessment and intervention to reduce their length of stay. Flow, capacity, and discharges within medical care remained challenging with long delays for patient.

The service was working with the wider health economy, this included meetings with the local authorities to review long stay patients who required complex packages of care.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and learning from incidents were discussed at safety huddles, handovers and in some ward team meeting minutes. We saw when the hospital had applied the duty of candour.

Staff were enthusiastic about the care and services they provided for patients. Staff felt valued and supported. Staff told us they felt supported by the team members and management. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work. Staff were proud of the positive feedback they received from patients and families.

We reviewed the feedback from the trust staff survey 2022 for the medicine and emergency care division. The division was below average in all 8 areas: “we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts, we are safe and healthy, we are always learning, we work flexibly, we are a team, engagement, morale”. We saw there was an action plan which had been updated in September 2023 which set out the divisions progress to against the divisional plan which also fed into the trust wide plan.

Patients had opportunities to give feedback on their patient experience whilst in the hospital. The trust had a Patient and Carer Experience Panel (PaCE). The PaCE Panel consists of public and staff representatives who work together in a collaborative approach towards quality improvement and patient experience within the Trust. A new structure for the PaCE Panel was agreed and commenced in 2022.

Staff could access various services to promote their wellbeing which included psychological, healthy living, physical and financial support. Pastoral care colleagues were always available to offer pastoral support to staff and attended team meetings.

Equality, diversity, and human rights training was part of the trust mandatory training programme. Data provided showed that 97% of nursing staff and 87% of medical staff had completed the training, which was below trust target of 90%.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures and process of accountability to support the services within the medicine and emergency care division. Clinical governance structures were set up and used across the division which reflected the clinical specialities.

The senior leadership team advised they had undertaken significant work on the governance process since the last inspection. The division had 3 managers (medical director, director of nursing and divisional director of operations) and they had regular performance meetings which mirrored the executive teams. This enabled them to review the key governance issues and be held to account for performance. The division also had a programme of away days to explore future developments of the service, to think strategically and building a 5-year plan to build improvements moving forward which filtered into plans and the vision.

Senior managers felt the clinical governance structures were effective and meetings were attended by staff who had senior roles and functions. Monthly boards meetings demonstrated that they reviewed the divisional risk register, medicines management, incidents, key themes and trends, Friend and Family Test, and recruitment. Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

Mortality and morbidity meetings took place and fed into the clinical governance meetings. These meetings were attended by a wide range of clinical and operational staff and followed a set agenda.

We spoke with matron and ward managers who demonstrated a good awareness of governance arrangements. Matron undertook monthly quality checks of patients' documentation, reviewing a random selection of 10 patents records on each ward. Ward managers also undertook additional checks on paperwork to identify areas of good practice and areas of improvement.

Nursing staff had regular handovers and safety huddles to escalate and share information from incidents. Wards had team meetings, however, the frequency of these varied and the minutes and agendas were not standardised. In minutes we reviewed, most had key themes such as patient safety, compliance, and current or topical issues.

Management of risk, issues and performance

Leaders and teams used systems to monitor performance however, we were not assured this was challenged effectively when performance was identified as poor. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The medicine and emergency care divisional risk register were trust wide and identified the top risks for the division (5) and the top risks for each speciality (3). The divisional risk registers also incorporated each specialities risk register, which meant all the risks were identified in one document. The senior leadership team identified their top risks as being the workforce, flow and overcrowding.

The triumvirates manage the risk registers and met regularly as a leadership team to scrutinise the risks and ensure they mitigate them and move forwards where they could. Matrons also would go through risk register with ward managers.

The risk register included most of the concerns we found during the inspection. However, the risk register was not sighted on mandatory training which was below the trust target for nursing and medical staff or nursing documentation.

Divisional governance meeting minutes recorded that the risk register was reviewed and noted additional risks added to the register. This meant the trust could evidence that risks identified were always being dealt with in a timely way.

A site summary dashboard was used to monitor performance across the hospital which included performance measures, such as discharge before 12 noon and before 5pm and length of stay. The dashboard gave senior leaders oversight of performance against targets; however, we were not assured how areas of underperformance were addressed across the wards.

A divisional scorecard was used to monitor matrons' quality audits across the across the division which included performance measures. The scorecard was RAG (red, amber, green) rated to highlight if the division was meeting its performance targets.

The trust had recently introduced quality metric information boards on wards which were updated daily. They displayed performance against key performance indicators such as falls, pressure ulcers, Clostridioides difficile and medication errors recording the number of days since this was last reported. However, it was clear how the quality boards were being used to drive improvements across the wards.

There were business continuity plans in place to maintain delivery of services in the event of planned or unplanned closure.

Information Management

The service collected reliable data and analysed it. Staff could not always find the data they needed. The information systems were integrated and secure.

Staff had access to patients' health records and the results of investigations and tests to support them to care safely for patients. However, doctors reported they were having to duplicate work when requesting scans and blood tests.

The hospital used electronic systems which allowed the service to manage quality and compliance processes and ensure audit completion. There was an electronic system that recorded patient's observations and helped with early identification of sepsis in real-time which allowed nursing staff to monitor change over time. This data was automatically uploaded to the electronic performance dashboard system. There were effective arrangements to ensure the confidentiality of patient identifiable data.

Paper based patient records were mostly stored securely in lockable trolleys on wards. Electronic information was held on a secure server which was only accessible by authorised staff members and required password access.

Staff had secure access to the trust intranet which gave then access to trust news, policies and procedures and their training and personal development records. Wards had information boards for staff, patients and visitors.

Medical care (including older people's care)

Information Governance and Data Security Awareness training was part of the mandatory training programme with 85% of nursing staff and 71% of medical staff having completed the training which was below the trusts target for mandatory training.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

Patients were encouraged to share their views on the quality of the service through the Friends and Family Test which is a national survey that measures how satisfied a person was with their experience of the service. In the period January to March 2023 the trust had an overall response rate of 6% with 98% of respondents across the trust rating their overall experience as ‘very good’ or ‘good’. However, the take up across the medical wards and AMA, AMU and short stay ward was low.

The hospital had set up a medicine patient experience group which was an initiative, made up of lots of different patients to help improve patient experience of their care and treatment at the hospital. Data provided showed the medicine patient experience group areas of focus for improvement were nutrition, discharge, and communication.

Staff had access to the Freedom to Speak Up Guardian Team within the hospital who they could approach to raise concerns freedom to speak up. In the period April 2022 to March 2023 a total of 237 concerns were raised by staff across the trust including doctors, nurses and therapy staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services and improvements from the previous inspection had been noted. However, staff were aware there were still improvements to be made.

Staff at all grades were committed to continuous learning. Staff we spoke with told us they were supported by their managers to develop their skills and access development opportunities. The hospital offered e-learning, classroom courses and specialist training programmes for both clinical and non-clinical staff.

The new acute medical floor had been redesigned to reduce the long hospital waits and improve admissions with direct referrals from patients’ general practitioners (GP’s). There was a plan to bring the acute medicine services together in one area. At the time of the inspection the same day emergency care was due to be relocated, bring together the acute medical assessment, the acute medical unit and the short stay ward. There were also plans to increase the opening hours..

The trust recognised and celebrated a range of events to highlight a range of themes and demographic groups, raising awareness of work undertaken and signposting to support, examples of these include carers week, learning disability week, black history month, deaf awareness week, human rights week and health literacy month.

Urgent and emergency services

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff and included training in life support. Over 90% of staff had completed their mandatory training, this was an improvement since our 2021 inspection.

Specific training on recognising and responding to patients with learning disabilities and autism did not form part of the mandatory training delivered. However, 60% of staff had completed training in this.

Staff told us they receive protected time to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

We saw that over 90% of staff received safeguarding adults and safeguarding children training specific for their role. This was an improvement since our 2021 inspection.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described how they would identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. Twenty-nine referrals had been made by the department in the 12 months before our inspection.

The safeguarding children and safeguarding adults policies contained details for staff on which agencies to contact if they had specific concerns. We saw a display for staff about how to identify possible victims of domestic abuse and how to escalate their concerns.

Cleanliness, infection control and hygiene

The service did not consistently control infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. Most of the furniture, such as beds, chairs, and mattresses were in good condition to allow for effective cleaning. All the curtains appeared in good condition, were disposable, and dates showed that they were regularly changed.

At our last inspection in 2021 we were concerned that the service did not ensure that staff complied with nationally recognised infection control standards. At this inspection we saw staff had access to personal protective equipment and this was used in line with national guidance. However, not all staff followed infection control principles. We observed staff who did not regularly sanitise or wash their hands when moving between areas. We also saw hospital staff visiting the department who were not bare below the elbow. There were no posters on the entrance to the department to let staff know they were entering a bare below the elbow environment. Being bare below the elbow helps reduce healthcare associated infections through contamination from cuffs and surrounding jewellery and watches.

Cleaning schedules had been completed. Cleaning schedules for July, August and September 2023 and demonstrated that all areas had been cleaned regularly. However, the escalation corridor floor was visibly dirty. Cleaning staff told us they had good leadership and direction in order to maintain standards. We saw cleaning staff working throughout the department during our inspection. We were told cleaning staff worked in the department 24 hours a day, 365 days a year.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Since our 2021 inspection, the provider had taken action to replace damaged and impervious surfaces, such as door frames. This meant these surfaces were easier to clean.

The service generally performed well for cleanliness. Audits showed a 97% compliance against recognised standards. There were regular walk arounds with senior staff and representatives from other departments to identify actions required to improve cleanliness, infection control and hygiene. We saw evidence that action to rectify issues raised on the walk arounds was taken and improvement was sustained.

We requested details of the hospital's patient-led assessments of the care environment (PLACE) scores. PLACE scores are the outcome of annual patient-led assessments of how the environment supports the provision of clinical care. The assessment includes the cleanliness and general building maintenance of each department. The results of the assessment we were shown from 2022 confirmed the department had passed the assessment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

At our last inspection in 2021, we had a number of concerns about the environment and equipment. The trust had made changes in response to some but not all of our concerns. Improvements had been made to the size of the resuscitation bays and the cubicles in majors. Improvements had also been made to facilities for children, people experiencing thoughts of ending their life, and families. However, the premises were not always secure to protect patients from the risk of harm and to mitigate the risk of equipment being tampered with.

The emergency department at Royal Shrewsbury Hospital was not the primary emergency department (ED) for children and young people. The main facility for this patient group was at The Princess Royal Hospital in Telford. At our last

inspection we were concerned that children arriving at the department were not protected or removed from seeing and hearing adult patients, some with complex needs. However, at this inspection we saw a specific treatment area for children and young people including a waiting room, there was also a bay in resus equipped with lifesaving equipment for babies, children and young people.

At our last inspection we were concerned that the dedicated resuscitation bay for children was also used for adults, this practiced had continued, and due to issues with capacity this bay was also used overnight to bed adults when the department was full. This meant a child presenting at the department with an acute illness or injury requiring lifesaving treatment could experience a delay in receiving this. However, we did not have any evidence a child or young person had experienced a delay in their care because of this.

We saw a ligature managed room for people with mental health issues which was quiet and free from equipment which could be used for self-harm or to harm others. This room was equipped with an easy reach call bell system to summon assistance quickly if necessary. There was a ligature managed toilet adjacent to the ligature managed room. Ligature managed rooms are safer spaces for patients experiencing thoughts of ending their lives. This was an improvement since our 2021 inspection.

Dedicated quiet rooms for staff to meet with families for confidential discussions and for breaking bad news had been introduced. These were sympathetically decorated and contained information to signpost families to support services. This was an improvement since our 2021 inspection.

Staff carried out daily safety checks of specialist equipment. Records showed resuscitation trolleys, which contained emergency lifesaving equipment were checked daily. There were dedicated staff allocated to this task as part of their daily routine. This was an improvement since our 2021 inspection.

At our last inspection we were concerned that the service did not ensure the premises were secure to protect patients from the risk of harm and to mitigate the risk of equipment being tampered with. In the ambulance receiving area (ARA) we saw doors with signs saying they were alarmed and not to be opened. We witnessed 2 different doors being opened, 1 of which led directly into a patient bay, no alarm was triggered on either door. This meant that premises were still not secure to protect patients from risk of harm or from equipment being tampered with.

Staff told us they were concerned alarms to call for staff to respond to an emergency, like a patient having a cardiac arrest and requiring resuscitation, could not be heard in all areas. For example, the alarm in parts of majors could not be heard by staff in ARA and the alarm in ARA could not be heard in parts of majors. They told us this meant medical staff would not always be aware there was a medical emergency that required their support. Hospital leaders told us this risk was mitigated in ARA by a combination of paramedics and registered nurses staffing the area and the close proximity of ARA to resus. This mitigation did not address the issue of resus being full or of staff, for example doctors, assessing patients in ARA or on an ambulance not being able to hear the alarm sounding to respond to an incident in majors. The risk was mitigated after our inspection by ARA relocating to a different part of the hospital where all alarms could be heard, and during our inspection we saw more than adequate numbers of staff responding to an alarm in majors.

We saw a fire door that did not close. Fire doors close automatically when the fire alarm sounds and help prevent the spread of fire. If the door is broken there is a risk it cannot help to keep people safe. We raised this as an issue with the nurse in charge who told us the door had been reported to estates and they had repaired the door earlier in the week. They said they would raise a new request for the door to be repaired again.

The main patient waiting area had been redesigned in December 2022, it was of a reasonable size to accommodate more people and had safe and well-maintained fixtures and fittings. It was light and spacious with toilets for visitors and had a water cooler and vending machine. The waiting area was L-shaped, and the position of the reception desk meant the reception team did not have visibility of most of the waiting area. Staff told us they were sometimes notified by patients that other patients had collapsed. Although security cameras covered the waiting area, the live feed was viewed by the security team and not by a clinician or a designated member of staff trained to alert the clinical team about a deteriorating patient. This meant that there was a risk of deteriorating patients not being identified in a timely fashion. We requested the risk assessment that covered the management of this issue but were not shown a copy of this. Instead, we were advised by hospital leaders that reception staff were responsible for flagging deteriorating patients to clinical staff either because they could see the deteriorating patient or relatives of patients alerted them to this. In addition, clinical staff moving in and out of the waiting area would identify deteriorating patients and escalate accordingly. However, longer term they aimed to identify a dedicated workforce to provide oversight to the waiting area.

As all patients arriving on foot had to access the service through the main waiting room children were not always segregated from adults while waiting for triage. However, children were prioritised for triage to reduce the amount of time they spent in the main waiting room. Once triaged children waited in the designated children's waiting area.

At our last inspection we were concerned that patients were sometimes cared for in escalation areas (corridors), including overnight. This situation had not improved due to the level of demand on the service and is addressed in the report below.

The service had enough suitable equipment to help them to safely care for patients.

Staff did not always place a call bell within the reach of patients, and patients on beds in ARA or on trolleys on the escalation corridor did not have access to call bells. However, these patients were in sight of staff, and we observed staff responded to their requests for support.

Hand soap and antibacterial hand gel was not always in secure dispensers. Therefore, there was a risk that patients were able to access and ingest potentially harmful substances. During our inspection a patient ingested a small quantity of hand sanitizer. When we raised this as a concern all lose bottles of hand sanitizer were removed.

The shower in the clinical assessment unit which was also used for patients with communicable illness like COVID-19, was out of order. Staff told us this was because of a long-term problem with flooding when the shower was used. There were no plans for the shower to be repaired. This meant in the likelihood patients with infectious diseases were confined to this unit they would not have access to a dedicated shower room.

We saw an improvement in how staff disposed of clinical waste safely. There were dedicated storage areas for clinical waste and bins for the disposal of sharps and medication were in line with national guidance.

Assessing and responding to patient risk

Staff did not always identify and quickly act upon patients at risk of deterioration. Overcrowding and lack of flow through the ED contributed to delays in identifying and acting upon patients at risk of deterioration.

Staff completed a triage risk assessment for each patient on arrival, using a recognised tool to categorise each patients' risk score. Higher risk patients were seen by medical staff sooner. The triage nurse streamed the patients to either the

urgent treatment centre, majors or minors. Patients brought in by ambulance received a triage from a 'navigator'. Once triaged the patient would be navigated to resus, the rapid assessment area, majors, minors, or the ambulance receiving area depending on their level of clinical need. When the department was at capacity the patient may be navigated back to the ambulance while space was being created in the department to admit them.

We saw patients on ambulances whose care was being provided by ED staff, but they could not be admitted to the department until a bed became available. Assessment and treatment of these patients continued from hospital staff while the patient was monitored by ambulance staff.

One patient on an ambulance whose care had been handed over to the hospital who did not have an identity band on. When the patient was moved into the department 3 hours later they had still not been issued an identity band. Identity bands help staff identify patients accurately and match them with the care intended for them, such as the right medication or diagnostic tests. However, all of the other patients we saw had been issued with an identity band.

At our last inspection in 2021 we were concerned that the provider did not ensure patients self-presenting received a triage within 15 minutes of arriving at ED in line with national guidance by the Royal College of Emergency Medicine. Waiting times for triage were between 15 and 19 minutes. However, staff told us waits sometimes went over an hour and could be as long as 2 hours. The internal audit on triage within 15 minutes for July, August and September 2023 showed in July 71.4% of patients were seen within this timeframe. This improved in August to 85.7% and to 100% in September. On the days of our inspection adults waited between 15 and 75 minutes for triage, and children and young people waited between 15 and 30 minutes for triage. During periods of very high demand there was a room that could be used as a second triage room for patients self-presenting to the ED.

Senior staff monitored children who left the department before being treated. Unless worsening advice had been given to parents or carers before they left staff were required to contact the family within 24-hours of their attendance to identify any harm as a result of children leaving before treatment commenced. A discharge letter was sent to the parents and carers, and the health visitor in the case of babies and young children. This process was overseen by consultants.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (version 2 – NEWS2) for adults and children over the age of 12 and a separate Paediatric Early Warning Score (PEWS) for babies and children under the age of 11. NEWS2 and PEWS are tools that help to identify acutely unwell patients, including those with sepsis. Patients who were registering a high NEWS2 or PEWS were flagged for medical review. Staff told us the NEWS2 or PEWS for each patient was reviewed every 2 hours. However, the NEWS2 audit for September 2023, showed that 70% of follow up NEWS2 observations were carried out within 2 hours.

The service used the sepsis 6 bundle if patients scored highly for sepsis. The sepsis 6 bundle is a set of 6 tasks that must be completed within the first hour of a potential sepsis case being identified including giving antibiotics and fluids to reduce the risk of mortality. The provider had a process to ensure staff acted promptly in response to suspected sepsis. This included a designated medical bleep holder being contacted so the sepsis 6 bundle could be commenced without delay. Nursing staff told us the doctor holding the sepsis bleep was always very responsive. Training in sepsis had been completed by 88% of the nursing team, however it had only been completed by 64% of the medical staff team. In addition to this, the NEWS2 audit showed that adults with a high NEWS2 were not consistently followed up in a timely way. For example, in September 2023 67% of these patients received time critical medication (antibiotics) within an hour and overall compliance with the NEWS2 tool was 81% in July, 83% in August and 81% in September 2023.

Urgent and emergency services

At our last inspection we had concerns that patient risk assessments were not always taking place which meant risks associated with the delivery of health care could be not mitigated. We saw risk assessments for each patient were mostly done on admission using a recognised tool but were not consistently reviewed regularly. This meant some risks, such as falls risk or risk of venous thromboembolism were identified at triage. Other risks, such as skin viability, were not always completed and when they were completed they were not always reviewed in a timely manner. In the 3 months before our inspection, 1 patient acquired a grade 1 pressure sore and 2 patients acquired a grade 2 pressure sore while in the department, and 149 patients were admitted with a pressure sore that required assessment and support to prevent worsening. We reviewed 17 sets of notes and found 9 patients had not had a second skin viability assessment. We saw evidence in 2 patients files that tissue viability risk assessments were not completed for 10 hours or more after the patients arrived in the department. We raised this as a concern, however, when we reviewed the patients notes 3 hours later, 1 patient's tissue viability assessment had still not been carried out. We saw evidence that when skin viability assessments were carried out at triage they were not consistently reviewed. We saw 2 sets of patient notes that demonstrated skin viability checks had not been reassessed after 10 hours and 24 hours, despite the patients scoring highly for risk of skin deterioration. The audits for assessment of skin integrity in September 2023 showed 75% of patients received an assessment within their first 6 hours in the department, 100% of patients received this assessment in August and 86% in July 2023. The audit showed that apart from August, patients were not consistently reassessed within 4 hours of initial assessment or provided with support with repositioning to reduce likelihood of worsening.

We found evidence of a culture within the nursing team where staff spoke to patients in a caring and reassuring manner, but the level of care provided did not always meet fundamental care standards. This culture appeared to be based on an out-of-date premise that intentional rounding was something done by nursing staff on wards but not in ED. In the last 5 years the amount of time patients spent in ED has increased. This meant aspects of care that traditionally may have been perceived as ward nursing was no longer specifically a ward-based activity. For example, giving bed baths or support to patients to wash or shower, repositioning patients to help maintain skin integrity and supporting patients to maintain good hydration levels. We saw that these fundamental care standards delivered through intentional rounding did not consistently take place.

On the second day of inspection, we saw 2 patients who had not had any skin viability or repositioning checks recorded. We raised this as an issue and 3 hours later this aspect of rounding had not been completed for 1 patient. We also saw 3 patients with urine bags left on their beds instead of on a stand, and 2 patients without fluids in reach. These issues were resolved by nursing staff as soon as we raised them.

Patients were assessed for their social risk factors, as well as medical conditions as part of the triage process. This allowed for signposting or referrals to other agencies to be made, for example, for support with homelessness, domestic violence and mental health services.

Shift changes and handovers included all necessary key information to keep patients safe. We attended 2 daily huddles, 1 for medical and 1 for clinical staff. We saw staff being given important information about patients to ensure continuity of their care, as well as other patient safety information being shared. Huddles took place 3 times a day at the start and end of each shift.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or with thoughts of ending their life. The service had 24-hour access to an onsite adult mental health liaison team if staff were concerned about a patient's mental health. The children's mental health team were based off site and did not offer out of hours support. Staff reported they could normally access adult mental health support quickly, and services for children easily during their operational hours. Staff told us they had not identified any risk to children by the children's mental health team not being available out of hours.

Urgent and emergency services

Children or young people who required specialist care at other hospitals were transferred in line with the trust's guidelines. In the 12 months before our inspection, 2 children were transferred to other hospitals more suited to their clinical needs. If required the on-site paediatric clinician at the Princess Royal Hospital in Telford could travel to assess and treat children at the Royal Shrewsbury Hospital, however, this arrangement did not extend to out of hours cover.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

We saw an improvement in both the numbers of staff deployed and, in the competency, and skills of staff, since our 2021 inspection.

The service had enough nursing and support staff to keep patients safe. Vacancy rates had reduced following a period of recruitment and there were just 3 nurse vacancies. However, we were informed that sickness rates had increased due to COVID-19, especially within the health care assistant cohort. Sickness absence and staff vacancies were covered through the use of agency staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing associates and healthcare assistants needed for each shift in accordance with national guidance. Nurse managers used a staffing establishment tool to calculate the number of nurses required to provide safe care and treatment. We saw allocations of nurses to patients were monitored by the senior staff to ensure staff with the right skills and knowledge to provide safe care. Staff told us there was always a qualified paediatric nurse on the roster. Nurses working in the paediatric area were trained in paediatric immediate life support (PiLS) and had completed a qualification in caring for sick children. Nurse managers told us during periods of escalation more staff could be drafted into the department from other areas of the hospital to ensure safe patient care was maintained.

The nursing team were supported by advanced nurse practitioners and a team of practice educators. The practice educators provided a staff induction including the induction for agency staff. Newly qualified staff told us they felt supported by the senior nursing team and practice educators. Their induction had been tailored to their specific learning needs and style. They had a clear set of competencies to work towards. However, some agency staff told us they were unable to access trust policy and procedure on trust intranet.

Managers limited their use of agency staff and requested staff familiar with the service.

Staff told us they always got their breaks, and when necessary, nurse managers or members of the nurse educators' team would cover breaks.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

We saw an improvement in both the numbers of staff deployed and, in the competency, and skills of staff, since our 2021 inspection.

Urgent and emergency services

The service had enough medical staff to keep patients safe. We saw staffing levels that matched planned numbers. During periods of escalation (when the ED had reached capacity) staff told us the hospital site team and hospital leaders would draft in medical staff from other parts of the hospital to ensure there were enough staff to provide safe care and treatment within the ED.

The service had low vacancy rates for medical staff. The recruitment of doctors had sometimes been difficult, which followed a national trend. Staff told us recruitment was most challenging in consultant roles, to mitigate this the department used regular locum consultants and shared out of hours on-call consultant cover with the Princess Royal Hospital in Telford.

Managers made sure locums had a full induction to the service before they started work. Agency doctors told us they received a 2-day induction to the department, as well as the same training and developmental opportunities as substantive staff. However, a junior doctor told us they did not receive an induction on internal professional standards, and they did not know where to find this document.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust had invested in employing Advanced Clinical Practitioners (ACPs). ACPs are health care professionals that have undertaken additional training to allow them to assess, diagnose, and treat patients including prescribing medication and referring on to other services. The ACPs were well managed in terms of oversight and skill mix.

There was a recognition that additional consultant and emergency nurse practitioner staff were required to meet demand throughout the 24-hour period across the trust. Trust leaders were due to commence a review to assess demand with the aim of improving access to the service for patients.

The trust had a successful international recruitment campaign to attract doctors. Internationally recruited doctors told us they were well supported had a minimum of 2 weeks induction, and a buddy system to provide ongoing support when needed.

Junior and middle grade doctors, and ACPs told us consultants were approachable, supportive and could be relied on to offer advice on medical and non-medical patient issues. They said they received protected teaching sessions, and training and development opportunities.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were a combination of written and electronic notes. The electronic notes were entered onto a hand-held device. There were not enough devices for each member of staff to have their own. We saw staff waiting for devices to become available so they could use them.

At our last inspection in 2021 we were concerned that the provider did not ensure paper records were consistently stored securely. We saw records were still not consistently stored securely. There were dedicated storage trolleys for patients notes with locks that could be opened quickly. However, notes trolleys were not regularly locked after use. Staff told us they did not routinely lock notes away because the nature of the service, and ongoing monitoring of patients meant records would need to be accessed without delay. On the first day of our inspection, we only saw 1 locked notes trolley. However, on the second day notes trolleys were mostly locked.

Notes were not always completed accurately or in a timely manner. We looked at 17 files, of these only 1 set of notes was completed correctly. Sixteen sets of notes had no evidence intentional rounding of patients had been carried out. Intentional rounding is a process of regular patient checks to address issues such as repositioning patients with skin viability risks, checking pain levels, and that personal needs like going to the toilet have been met. Notably, we saw that skin viability assessments did not consistently form part of patient notes. We raised this as a concern on day 1 of our inspection and on the second day we saw booklets to record intentional rounding formed part of most patient records.

In addition to this, fluid balance charts were not consistently completed for patients in receipt of intravenous fluids in line with National Institute for Health and Care Excellence guidelines. We saw 2 out of 3 patient notes for people prescribed IV fluids that did not include a fluid balance chart.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

At our last inspection in 2021 we were concerned Staff did not always store medicines in line with good practice. Although checks were undertaken daily to ensure they were stored at the correct temperatures, the ED Majors store records showed the room temperature was regularly above the acceptable temperature required to ensure medicines maintained their effectiveness. This issue had been reported by staff in April 2023 but had not been resolved. Records showed medicines stored in refrigerators were kept at the appropriate temperature. Medicines were stored in locked rooms. Controlled drugs were kept in locked cabinets and their administration and destruction was in line with Home Office requirements.

Staff completed medicines records accurately and kept them up to date. We reviewed 3 patient records and noted patients' medicines administration records were completed accurately. There were prompts in records when patients' conditions required medicines to be administered on time. Weekly audits were completed to identify any discrepancies in medicines stock. Records had not identified any anomalies which could suggest medicines had been wrongly prescribed or misplaced.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Patient records identified medication administered and this information was also shared verbally when patients were handed over to other services.

We reviewed 2 resuscitation trolleys and saw emergency medicines were available to staff and medicines were regularly checked to ensure they were within their use by date and remained effective. This was an improvement since our 2021 inspection.

Patients were able to request and obtain pain relief when they needed it. We reviewed the Patient Group Directions (PGD) for pain relief medicines. These were in date and staff were using the correct processes. PGDs permit the supply of prescription-only medicines to groups of patients, without individual prescriptions. It is a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

One of the patients we spoke to told us their medicine had been left by their bed instead of them being supported to take it. This meant the person who dispensed the medicine could not be sure the patient received it.

Medicine reviews were undertaken by pharmacy staff and staff reported requests for medicines were mostly responded to in a timely manner. At our last inspection we were concerned that emergency medicines were not always available

within the ED. We saw this issue continued to be a problem in some areas of the department. Staff on AMA told us they sometimes had difficulty getting hold of some frequently used medicines like antibiotics because of infrequent deliveries of medicines from the pharmacy. This meant staff had to leave the area they were working to locate drugs elsewhere in the department.

Empty oxygen cylinders were stored securely on a corridor within the department. This was listed on the departments risk register as an ongoing risk.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them and raised concerns and reported incidents and near misses in line with trust policy.

From 9 September 2022 to 8 September 2023 the trust reported 27 serious incidents in urgent and emergency care, 13 of these related to a diagnostic incident including a failure to act on test results. Other serious incidents included: 7 slips, trips or falls, 6 treatment delays and 1 surgical procedure. A further 4,985 incidents were reported over the same period. The most commonly reported incidents included: access, admission, transfer, discharge (2,049), implementation of care and ongoing monitoring and or review (1,243), infrastructure (including staffing, facilities, and environment) (408) and clinical assessment (including diagnosis, scans, tests, assessments) (238).

Staff told us they normally received feedback from managers about the incidents they had reported.

We saw evidence of learning from complaints and incidents. Staff shared feedback from investigations and incidents, both internal and external to the service. Staff met to discuss the feedback and looked at improvements to patient care. Incidents were reviewed at a rapid review meeting so they could be rated and investigated according to risk. The outcome of these investigations were cascaded down through the staff team at huddles and included in the weekly newsletter. Messages of the week were also shared at huddles, these reflected new or emerging themes from incidents and complaints.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence that changes had been made as a result of feedback. For example, out of date paperwork had contributed to a serious incident so managers ensured staff checked all paperwork was for current use and out of date forms were destroyed.

Staff told us managers debriefed and supported them after any serious incident.

Urgent and emergency services

Is the service effective?

Good

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

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed mostly up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw policies were based on up-to-date clinical guidelines for example the British Thoracic Society guidelines were used for the management of patients with asthma. However, the neutropenic pathway for oncology patients was based on outdated policy, staff were aware and told us this pathway was undergoing review.

We saw evidence of pathways in patient files which contained clear information for staff to follow to ensure patients received the right care.

Most staff told us they knew how to access the service's policies and guidance documents on the trust intranet. However, some agency staff told us they were unable to access trust policy and procedure on trust intranet. This meant managers had not checked to make sure all staff followed guidance. Not all medical staff were able to access the trust's professional standards. This meant medical staff did not have a consistent understanding of the decision-making processes that underpinned patient care.

We did not see any patients who were subject to the Mental Health Act. However, staff we spoke with could describe the Act and knew how to follow the Code of Practice. This meant if someone had been 'sectioned', or kept in hospital under the Mental Health Act, staff would understand how to protect their rights. Patients who lacked capacity to fully engage in treatment and patients who had thoughts of self-harming and/or ending their life were given one to one support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a nursing staff handover huddle which identified patients who lacked mental capacity and relatives or carers who advocated on their behalf. The requirements of patients with psychological needs was discussed including how care was to be delivered to keep them safe and reduce their anxiety.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

At our last inspection in 2021 we were concerned that the provider did not ensure patients who require food and drink within the department had their dietary needs assessed and planned for. We found that despite raising these concerns staff did not consistently make sure patients had enough to eat and drink, including those with hydration needs. Drinks were not always placed within the reach of patients putting them at risk of not being able to meet their comfort or hydration needs and staff did not fully and accurately complete patients' fluid and nutrition charts where needed. We saw patients who were receiving fluid via a drip and patients who had been catheterised who did not have a fluid balance chart. We looked at the notes of 3 patients who met this criterion and saw that only 2 had fluid balance charts. We also did a quality round with one of the nurses in charge to assess the care received by patients, we saw 4 patients at

that time who should have been monitored through the use of a fluid balance chart, but only 2 of these patients had them. An audit for the 3 months before our inspection showed that patients who required monitoring through a fluid balance chart did not consistently receive this level of care. Fluid balance charts were used for 59% of patients who required them in July, 59% of patients in August, and 89% of patients in September 2023.

Staff told us there was a focus within the department to ensure patients were offered food at mealtimes. Patients told us that staff offered them food, and hot and cold drinks. The food that was offered was normally soup, toast, or a choice of sandwiches to meet religious, cultural and other needs. However, we found the food that was available may not have met the needs of patients spending extended periods of time in the department. We saw patients who spent more than 3 days in the department who had not been given any cooked meals.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

We saw staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. This was an improvement since the 2021 inspection. Patients received pain relief soon after it was identified they needed it, or they requested it. Patients told us they were regularly asked about pain, including at triage, and were given pain relief quickly once they had requested it. Some pain relief was able to be safely dispensed without authorisation of a prescribing clinician to speed up this process.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff mostly monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

We saw the results of the Royal College of Emergency Medicine (RCEM) audits were used to improve patient care. The RCEM audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care given against 3 treatment criteria each year. This was an improvement since the 2021 inspection.

We saw evidence that managers and staff carried out a comprehensive programme of repeated local audits to check improvement over time. For example, on patients who left the department before being seen, and if patients had received a computed tomography (CT or CAT) scan of the brain following a head injury or suspected stroke. The audits showed where improvement in treatments could be made. Managers shared and made sure staff understood information from the audits.

Managers and staff used the results of audits to improve patients' outcomes. Action plans to improve performance, for example in sepsis management, were in place and were updated and discussed regularly within the clinical teams. Actions included increasing staff training to improve detection of sepsis and introducing technology to enhance recording and management of the condition.

The trust participated in a getting it right first time (GIRFT) programme. This involves scrutinising patient outcomes and making changes to pathways to improve outcomes for patients. The trust was also engaged with regional and national benchmarking projects to try and improve standards of care within the trust, this included learning from other trusts with better patient outcomes.

The trust did not monitor the time it took for speciality teams to respond to requests to assess and transfer patients out of the ED. So, delays to hospital inpatient admission for patients waiting for more than 5 hours from time of arrival at the ED was not something the trust could provide us information on. As delays of over 5 hours are associated with an increased 30-day mortality rate (death from any cause) this meant the trust was not correlating 30-day patient outcome data with delays in ED to help measure patient outcomes.

The service had a lower than expected risk of re-attendance than the England average. The trust's percentage of patients that reattended the EDs within 7 days of a previous attendance was consistently lower than (better) the England and regional averages from June 2021 to May 2023.

Competent Staff

The service made sure staff were mostly competent for their roles. Managers did not consistently appraise staff's work performance, but they held supervision meetings with them to provide support and development.

We found staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients in the department. This was an improvement since the 2021 inspection.

The clinical educators supported the learning and development needs of staff. A training team of 4 practice educators for nursing staff were employed to ensure nurses were competent, had regular clinical supervision, and annual appraisals. Guidelines used for skills and competency framework were based on clinical guidance from the Royal Marsden Hospital Manual of Clinical Nursing Procedures, the National Institute for Health and Care Excellence and the Royal College of Nursing. Staff were able to work towards developing new competencies at a pace that suited them.

The training team developed a matrix for oversight of staff competencies which enabled them to generate a monthly training needs analysis to ensure training needs were met. The team had also implemented a staff mentor program so staff had a point of contact for ongoing support as necessary. The training team had developed a system of champions. This meant there were nurses with specialist knowledge in subject like tissue viability, infection control, and diabetes. Champions were able to deliver training, as well as specialist support to the wider staff team.

To ensure a strong understanding of emergency treatment, training in the use of the tool used to triage new patients was provided to band 6 nurses only when they had worked in the department for at least 6 months.

We saw evidence that staff working with children and young people received paediatric immediate life support training and caring for the sick child training. Managers told us they made sure at least 1 registered children's nurse was rostered on each shift. However, the staffing template was for 2 registered children's nurses or 1 registered children's nurse and an ED nurse with paediatric competencies.

Managers gave all new staff a full induction tailored to their role before they started work. All staff including agency staff told us they received an induction before they began working in the department. Agency staff received a 2-day orientation induction. While on their induction, to develop competencies and confidence, newly qualified nurses were supernumerary for up to 8 weeks, longer for internationally recruited nurses.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Medical staff told us they had regular protected teaching time each week.

Managers did not consistently make sure staff received any specialist training for their role. We saw in 2 people's records that staff had been unable to promptly carry out care because they lacked the specialist skills. In one patient's notes a nurse who had been asked to catheterise a patient was unable to do so. Notes of a patient who required a lumber puncture recorded there was a delay of approximately 2.5 hours before the procedure was attempted because staff were unable to find a doctor with the skills to carry out the process.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Although 100% of medical staff had received an annual appraisal, only 65% of clinical staff had received an appraisal in the 12 months before our inspection.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers were recruited through the provider's central selection process. Their tasks included making patients' drinks, reassuring patients and restocking laundry stores.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff also received a weekly newsletter containing important messages.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw staff working across health care disciplines as a multidisciplinary team to benefit patients. We saw doctors and nurses working with staff from the respiratory ward, the mental health team, physiotherapists, the frailty team and the oncology team.

Staff mostly worked well across health care disciplines and with other agencies when required to care for patients. Doctors from the medical team worked in the ED to assess and care for their patients. Speciality doctors were mostly responsive when asked to review patients in the ED although there were delays for some patients. For example, a patient required admitting but a disagreement over which department, trauma and orthopaedics or medicine, would accept the patient meant there was a delay of over 29 hours in treatment and the patient remained in ED longer than necessary.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The service operated 24 hours a day, 365 days a year. Staff could call for support from doctors and other disciplines and diagnostic services, including adult mental health services, 24 hours a day, 7 days a week.

Out of hours consultant cover was shared with The Princess Royal Hospital.

Mental health services for children and young people were not available out of hours. However, staff told us they had not experienced any delays in getting support from this service during their operating hours.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff received and mostly kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, staff told us they did not impose DoLS in the department, but they understood and could tell us about the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, MCA and the Children Acts 1989 and 2004, and they knew who to contact for advice. Data showed 100% of key staff received training in the MCA and DoLS.

We saw a patient with Alzheimer's who was sedated because they were verbally and physically aggressive. They had been in the department for 34 hours and were sedated soon after their arrival. An application for a DoLS in this instance would have been appropriate to maintain the legality of the deprivation of the patient's liberty.

Staff completed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms with patients and their families in line with national guidance. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency, for example cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both patient preferences and clinical judgement. The agreed clinical recommendations that are recorded include a recommendation on whether or not cardio pulmonary resuscitation (CPR) should be attempted if the patient's heart and breathing stop. We looked at ReSPECT forms for 2 patients and saw they had been completed accurately and legitimately. This meant patients and people with the right to act in their best interests had been involved in making future care decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed a nurse discussing a patient's ReSPECT form with social workers. They agreed they would need to seek the consent of the patient and family again as their views had been obtained some time ago and their wishes may have changed.

Is the service caring?

Requires Improvement

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

Compassionate care

Although individual staff members treated patients with compassion and kindness, the service was not being delivered in a way that always respected patients' privacy and dignity.

At our last inspection in 2021 we were concerned that the service did not consistently protect the privacy and dignity of patients. At this inspection we found staff were still not consistently discreet and responsive when caring for patients. However, staff took time to interact with patients and those close to them in a respectful and considerate way.

We noted on 4 occasions that screens for patients being nursed in corridors did not always protect their dignity when receiving personal care. Screens were short and could be looked over or had gaps the patient could be viewed through.

On 1 occasion in the ambulance receiving area, we were able to see between the screens and observe a patient being supported to change their nightwear. On another occasion a patient had removed their bedding, leaving themselves exposed. We saw several staff walk past without repositioning the covers. On the escalation corridor we could view patients being supported to use bedpans. We saw a patient in a bay who was naked from the groin down who had not been supported to cover their intimate areas.

People of different genders could not be separated in escalation areas. This meant patients could not always have their personal needs met, like having a wash or using a bed pan, in an environment where the other patients were the same gender as them.

Patients said staff treated them well and with kindness. All patients we spoke with were complementary about the staff who supported them. They said staff were polite and responsive to their needs. Examples included staff bringing drinks when requested and contacting relatives on their behalf. Patients said they received regular updates about their conditions and care plans to minimise any anxiety. However, we saw a patient in distress because they were being denied use of a toilet, and despite not being incontinent, were told to use a bedpan and had been issued with an incontinence pad. We also saw 2 patients that had not been supported to wash or change their clothes despite both having visibly dirty faces and clothes.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Relatives and carers of patients with dementia and special needs said staff took time to interact with these patients. Staff took time to explain people's care in their preferred style. The carer of one person with a learning disability said staff would direct their conversation to the patient using their preferred name so they felt included but allowed the carer to add further clarity if required.

Staff understood and could explain to us how they respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quiet room for use by patients who were at risk of becoming distressed. We saw a patient with mental health needs was cared for behind a closed curtain with a relative present. This provided the person with a calm space which supported their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There were dedicated quiet rooms for staff to meet with families for confidential discussions and for breaking bad news, and a side room where end of life patients and their families could have their privacy and dignity maintained. These rooms were sympathetically decorated and contained information to signpost families to support services.

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We mostly saw staff demonstrating sensitivity and offering reassurance to patients and their families. However, we witnessed 1 patient on the escalation corridor who was forced to wear incontinence pads despite not being incontinent and refused support to use the toilet. When we raised this as a concern staff from majors supported the patient to use the toilet.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. Patients told us they had been supported by staff who knew their specific needs. The carer of a patient with a learning disability said staff had remembered the person from a previous visit and remembered to refer to them by their preferred name. This had made the patient and carer feel welcome and confident the staff who supported them knew their specific needs and preferences. We saw staff contacting the learning disabilities team to help support the communication needs of patients with a learning disability.

Staff supported patients to make advanced decisions about their care. We saw staff completed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms with patients and their families.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Details of how to raise a concern or make a complaint were available on the trust's website. However, feedback from the Family and Friends Test (a national survey, providing people who have accessed the NHS an opportunity to provide feedback on how satisfied they are with their experience of care) was low with 18 (0.3%) of 6,920 eligible patients leaving feedback in September 2023. Of those 8 people said their treatment was very good, 8 said it was poor or very poor and 2 people said it was neither good nor bad. Three respondents left comments about care, 2 were complimentary about the care provided. The third was a comment about leaving a patient in their nineties in the waiting room for over 7 hours.

We saw evidence that the trust was working to develop systems that could increase the number of patients who feedback on care to help them improve the patient experience, including the introduction of feedback through text messaging.

Is the service responsive?

Inadequate

Our rating of responsive stayed the same. We rated it as inadequate.

Service delivery to meet the needs of local people

The service was not designed to provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers tried to plan and organise services, so they met the needs of the local population but due to pressures in the wider health and social system the department, along with the wider hospital, was gridlocked. This meant facilities and premises were not always appropriate for the services being delivered. The service was consistently in escalation due to the capacity of the department. This was because patients could not always be transferred out of the department in a timely way. Subsequently patients were being looked after in parts of the department that were not always appropriate to meet their needs such as the fit to sit area and escalation areas.

'Fit to sit' was used when there were no more beds for patients, but patients still needed to be in the department, and they had been assessed as clinically well enough to sit up. The standard operating procedure (SOP) that provided staff with guidance about which patients met the criteria to wait in fit to sit was agreed in March 2023 and specified up to 15 patients could wait there while overseen by 2 registered nurses and 1 health care assistant. We sat in this area for 15 minutes with 3 patients and did not see any staff, other than staff who walked past the area on their way to somewhere else. The area was being used for patients who were waiting for a bed on an inpatient ward or who were waiting to be seen by a specialist medical or surgical team from elsewhere within the hospital. One patient had been waiting to be reviewed by a surgical team for over 8 hours, they told us they had been given pain relief but were still in pain and were not comfortable sitting. Another patient had been waiting for 13 hours (overnight) to be seen by a specialist consultant. The third patient had originally been in a bed was moved to the fit to sit area due to a more clinically unwell patient needing the bed overnight. They were moved back to a bed once 1 became available, at that point the patient had been in the department for 26 hours. This meant patients who did not always meet the criteria to wait in the fit to sit area were sometimes moved there because of the high level of demand on the service.

The department had a SOP to govern the number of patients that could be nursed in escalation areas. An escalation area, normally a corridor, was part of the hospital that was only used as a temporary measure to provide care and treatment to patients when capacity in the department outstripped demand. The escalation areas did not have patient call bells and they did not all have enough space for patients to have a locker to keep their possessions in within easy reach, or for a table to put water or food on. The ambulance receiving area (ARA) had been assessed as being able to have 4 escalation beds on the corridor, but staff informed us sometimes up to 7 people were placed there. There was an escalation corridor which could be used for up to 4 patients on trolleys. While we were on site escalation beds were consistently being used. This meant patients were in spaces not designed for sick patients. It also meant that very poorly patients who relied on staff to meet their personal care needs could not always be provided with a private space to maintain their dignity. The demand on the service was so high that patients were often in these spaces for many hours or more than a day at a time. We saw an escalation bed created for a patient within majors during our inspection, this escalation area was not included on the escalation SOP.

We saw a patient in an escalation bed on ARA who had been in the department for 34 hours. They had a cognitive impairment and an acute physical illness. The patient had been sedated because they were verbally and physically aggressive. The patient's notes clearly stated they were not suitable for corridor care; they had been annotated with the following NFFCC which meant not fit for corridor care. We raised this as a concern with staff because the patient was being cared for on the ARA corridor. We were told NFFCC only meant not suitable for the escalation corridor.

Staff could access emergency mental health support 24 hours a day, 7 days a week for adult patients with mental health problems, learning disabilities and dementia. Mental Health Liaison nurses were present in the service and staff said they were always readily available for advice and assistance. There was a mental health nurse champion who also provided support and training for staff.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw wheelchairs were available in the main waiting area to help support patients access the service. We observed staff promptly supply a wheelchair to a patient who was at risk of falls. Additional wheelchairs were available from the Outpatient Department if required.

Meeting people's individual needs

Patients did not consistently have their personal needs met. However, the service mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We observed staff ask patients their wishes and observed staff review a person's records to ensure care was delivered in line with their expressed preferences.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Records of people living with dementia and learning disabilities included their likes, dislikes and their preferred choice of communication.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was guidance displayed for staff on how to access support such as learning disability liaison nurses, and communication cards to support people to express their views and needs. Staff were prompted to ask specific questions to patients with a disability, their relatives and carers in order to make sure all their needs were known.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to interpreter services and British Sign Language support via telephone and videocall.

Patients were given a choice of food and drink to meet their cultural and religious preferences. People we spoke with said they received food and drinks they liked. Staff regularly asked if patients were thirsty or hungry. Food and drinks were available from the provider's catering service to meet people's religious needs, such as vegetarian and Halal sandwiches.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had produced a pack of signs and symbols for nonverbal communication. These included cards that helped patients explain how they felt, such as if they needed a drink or were experiencing pain.

People of different genders could not be separated in escalation areas and there are no rules that say people of different genders must be segregated in EDs. However, this meant patients could not always have their personal needs met, like having a wash or using a bed pan, in an environment where the other patients were the same gender as them. Instead, patients were separated by a portable screen.

We saw patients on ARA had been given support to have a wash or shower and they had been offered personal care kits containing soap and other personal hygiene products free of charge. However, on the first day of our inspection we saw

patients in other areas of the department that had not been supported to wash or change their clothes which showed obvious signs of dirt and or blood. When we raised this as an issue with 1 member of staff they said patients on ED did not need to be, or have support to be, washed or have their clothes changed and that was something that happened on wards.

Helping patients wash and change into clean clothes is part of intentional rounding. Intentional rounding, often referred to as rounding, is a process used by nursing staff to carry out regular checks, usually hourly, with patients using a standardised protocol. Rounding addresses issues of positioning, pain, personal needs, and placement of items, in an emergency department it might also include an assessment of patients' psychological wellbeing and a review of their time critical medicines. Rounding to meet peoples' individual needs was not consistently carried out with patients in the department, especially on the first day of our inspection. As well as patients who had not been supported to wash or change their clothes we saw patients that had not been repositioned, patients without fluids, and patient's belongings scattered across their bay, included items of clothing that were left in balls on chairs and or tables. We raised this as an issue and on the second day of our inspection we saw booklets to record rounding had been added to patient files and evidence that rounding had taken place, and we did not witness patient who were dirty or who were wearing dirty or bloody clothes, or any untidy bays.

Access and flow

People did not always have timely access the service when they needed it. The service was not meeting national standards to admit, treat, transfer or discharge patients within 4 hours. There was a declining picture, consistent with increasing numbers of patients coming into the service.

At our last inspection in 2021 we were concerned that the service did not ensure patients could receive care in a timely way. We found this issue had not been resolved because of the continued level of demand on the service, and issues within the wider health and social care system which had created a gridlocked hospital.

There were long-standing local and national issues with access and flow through the whole health and care pathway which resulted in 'gridlocked' or full hospitals. These included an increase in demand for services from an aging population living for longer with more conditions, insufficient capacity in adult social care continuing to contribute to delays in discharging medically fit people from hospital, and difficulty for some people getting care from a GP practice having a knock-on effect for emergency departments. From April to June 2023, the trust's ED occupancy was frequently over 250% which led to delays within the department. Senior ED leaders demonstrated a good understanding of these issues and were working in collaboration with other divisions within the hospital and their system partners to try and improve flow within the wider hospital and the system generally. Patient flow coordinators had been recruited and were working to help identify opportunities to increase flow in the hospital and wider system to create capacity in the ED. Several initiatives had been introduced including virtual ward services which were well established within the local health economy. There were a number of pathways to support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. The team were continuing to work with external partners on initiatives to help some patients avoid admission to hospital when they could be treated at home, as part of a virtual ward, or by other community-based services.

We attended 1 of the virtual internal meetings that focussed on what could be done to improve flow within the trust. The meeting was held 3 times a day and was attended by a wide range of staff who worked together to identify how flow could be generated through the safe discharge of patients back into the community. We then attended a virtual meeting with external system partners who worked together to identify how system wide flow could be improved. This meeting

was held once a day or more often if the system was in escalation. It was evident from these meeting that the hospital and wider system were gridlocked and very little movement to create flow could be achieved. ED managers told us the level of escalation the department was in was not always communicated to them following these meetings, this meant they were not consistently able to implement their escalation or de-escalation systems.

The patient flow coordinator, managers and staff were unable to make sure patients did not stay longer than they needed to. The department was significantly overcrowded, this was because many of the patients required an inpatient bed in the hospital on a medical, orthopaedic, or surgical ward, but they could not be transferred because the wards were full. This meant patients often stayed in the ED for many hours after their treatment there was finished. We saw patients who had been waiting for beds on a ward for up to 58 hours. Mid-morning of our second day on site there were 57 patients in the ED, of these 29 patients were waiting for a bed on a medical ward, 6 patients were waiting for beds on an orthopaedic ward, 5 patients were waiting for a surgical bed and 2 patients were waiting for transfer to a mental health facility. One patient was medically fit and was waiting for a community-based package of care so they could be safely discharged. This meant there were only 14 patients in the department requiring urgent and emergency care.

Trust leaders monitored waiting times but due to the demand on the department they were unable to make sure patients could always access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends patients wait no more than 1 hour from time of arrival to receiving treatment. The trust consistently reported a longer median time from arrival to treatment compared to the England average from June 2021 to May 2023. However, there was a considerable decrease from 2 hours 30 minutes in December 2022, to 1 hour 30 minutes in May 2023. Over the same period, the England average decreased at a slower rate from 1 hour 32 minutes to 1 hour 5 minutes.

Under the NHS constitution EDs have a waiting time target for 95% of patients to be admitted, transferred, or discharged within 4 hours. The trust's percentage of patients meeting the 4-hour target showed little variation over the most recent 12-month period. The percentage was 47.4% in June 2022, and 46.4% in June 2023. The trust's percentage was lower (worse) than the England and Midlands averages.

The average monthly number of patients waiting over 12 hours from the decision to admit to admission from July 2022 to June 2023, was 2.5 times higher than the average for July 2021 to June 2022.

The navigator assessed which part of the ED patients being brought in by ambulance should start to receive their treatment in. Patients received care and treatment in the ambulance receiving area (ARA) or on their ambulance if there was no room in the ED. If necessary medical staff would go out to ambulances to assess patients and carry out tests, for example urgent blood tests to help make a diagnosis. On the first day of inspection, we saw 1 patient in ARA who had been there for 36 hours, staff told us it was not uncommon to have the same patient in ARA for over 40 hours. Escalation beds in ARA were in constant use during our inspection.

The proportion of patients who attended by ambulance and waited over 60 minutes from arrival to handover from December 2022 to August 2023 was consistently higher (worse) than the average percentage for regional ambulance service. Although ambulance handover delays had decreased from 56% of patients waiting over 60 minutes to be admitted in December 2022 to 32% in August 2023. Regional ambulance patient handover delays also decreased over the same period from 28% to 11%.

We reviewed the notes of a patient who had waited 11 hours in ED to be seen by the trauma and orthopaedic team. The trauma and orthopaedic team told ED staff the patient required a review by the medical team. Twenty-nine hours later there was no decision to admit the patient. The trust's internal professional standards made it clear the patient should

not have been left in ED, instead the timely assessment and transfer to an appropriate ward under the care of a specialist team should had taken place. This highlighted that the trust was not implementing the internal professional standards consistently to provide support tothe department, and the risk was being held by the ED rather than shared across trust divisions.

In the 3 months before our inspection 974 patients left the service before being seen, 79 of these patients were aged 17 or below. Staff monitored children who left the department before being treated and made contact with the family within 24-hours of their attendance to identify any harm as a result of children leaving before treatment if they did receive worsening advice from staff before they went home. There was a system to inform support services, for example, a safeguarding team if there were ongoing concerns about the welfare of a child.

Staff planned patient discharges carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment. However, due to a national shortage of mental health inpatient beds and blockages in social care staff told us there were often delays in discharges for these patients.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern on their website.

Staff understood the policy on complaints and knew how to handle them. Senior leaders told us they supported staff to meet with patients and families to help resolve complaints. They also invited the people who made complaints to become involved in patient representation groups to help improve treatment services.

Managers investigated complaints and identified themes. They involved patients and their families in investigations. Managers shared feedback from complaints and investigations with staff and learning was used to improve the service. In the 6 months before our inspection the trust received 106 complaints about the EDs, some complaints covered more than 1 theme. The main themes were, clinical treatment (55), communication (39), attitude of staff (33), admission and discharge (29), and patient care (28). We saw the trust had plans to develop a video for use in the waiting area to give patients key messages to help improve communication and improve patient expectations about the service.

Is the service well-led?

Requires Improvement

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

Leadership

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

Urgent and emergency services

Staff told us they felt well supported by their senior team. They said they were visible and approachable, and the department worked well as a strong team. All those we met in the staff team said they felt confident and able to speak up to senior staff and managers. There was a learning culture in the department and effective support for staff to train and develop into more senior roles and learn new skills.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy that was in the planning phase, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The emergency department (ED) vision mirrored the trust-wide vision to provide the best possible care to patients. The strategy, which was largely in the planning phase, was focussed on improving flow and patient pathways to improve the patient experience.

The vision and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. The strategy involved working in partnership with the integrated care system to get medically fit patients out of hospital as soon as safe to do so to improve flow within the wider hospital. Senior leaders recognised there was a direct corelation between the number of medically fit patients in the hospital, who could not be discharged to an adult social care placement or to their own homes with a bespoke package of care, with the number of patients waiting to access treatment whilst sat outside the ED in the back of an ambulance. The vision for the department also involved increasing community-based treatment to help avoid patients being admitted to hospital whenever possible and reducing the amount of time patients spent in hospital if they required an admission. Ultimately this would help patients to access urgent and emergency care when they needed it.

While the vision was aligned to local plans in the wider health and social care economy, and services were being planned to meet the needs of the relevant population the strategy was still largely in the planning stages and was not fully operational at the time of our inspection. This meant at the time of our inspection there was not a strategy in place that could effectively reduce the amount of time patients spent in the back of an ambulance waiting to be handed over to the ED, or the number of patients being nursed in the ED instead of on a ward, or provide poorly patients who needed a bed instead of having to sit in the fit to sit area while waiting for treatment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. Staff felt supported, respected, valued and were positive and proud to work in the organisation.

Nursing staff told us the culture was centred on the needs and experience of people who used services.

Nursing staff told us they felt able to speak up when they had concerns and that managers listened to them and helped find ways to resolve problems. All of the staff we spoke to could tell us who the freedom to speak up guardian was.

Medical staff told us they felt listened to by their immediate managers. However, when they raised concerns through the Freedom to Speak up Guardian about risk to patients receiving care in escalation areas, specifically the escalation corridor, they said no meaningful action was taken by hospital leaders.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively.

The trust was going through a large-scale program of transformation including a reconfiguration of urgent and emergency care services. It was notable that no staff below management level spoke to us about the transformation.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders described effective structures, processes and systems of accountability to support the delivery of services. All levels of governance and management functioned effectively and interacted with each other. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. This was an improvement since the 2021 inspection.

At our last inspection we raised a number of concerns about the care and treatment of patients and while we were pleased to see many of these issues had been resolved some had not. The provider had failed to take effective action on several of our concerns. For example, patients were not consistently triaged within 15 minutes of arrival, and the provider did not consistently ensure risks associated with the delivery of health care was mitigated as far as was reasonably practicable for all patients.

However, senior leaders explained that the executive board were well sighted on the challenges facing the ED and there were good lines of communication, that the board listened and were sympathetic and would take immediate action to support the department when they could although they did not always have the means to provide a solution. Hospital leaders sent us evidence to show some of the initiatives which focussed on hospital discharges to try and improve flow within the hospital. However, the level of demand on the service outstripping capacity appeared to be a much bigger problem than could be resolved by the trust alone.

Senior leaders described a process of rapid review to learn from incidents and systems to ensure learning was disseminated to teams. We saw evidence of this including how services had been changed to reflect learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues but did not always have the ability to implement actions to reduce their impact.

Managers in ED were not always aware of how the hospital's EDs were represented in the internal daily meetings and in meetings with system partners. For example, leaders were not always made aware of changes to the level of escalation the ED was assessed as being at, or when the department could de-escalate. This meant ED managers could not consistently put escalation or de-escalation systems into operation.

We saw risk register entries reflected the issues staff told us were the biggest risks impacting the delivery of safe care and treatment. This was an improvement since the 2021 inspection. Although, these were risks that had been on the

register for a long time there were some actions completed and mitigated and other actions were not completed to bring about a change in risk levels. For example, in July 2018 an entry was added to the register to reflect that the ED were unable to consistently maintain clinical assessment of patients in line with policy. It was recognised this risk could impact on diagnosis and treatment of potentially critically unwell patients and there was evidence that steps had been identified to reduce the risk, but the first step towards closing the risk was not recorded as being done until October 2023. With other steps still to be taken it remained an active risk for the department.

The service used evolving standard operating procedures (SOPs) to help manage risk. This meant that procedures could be changed to manage risk flexibility to take into consideration, for example, changes in demand or in staffing levels. Leaders told us they used an evolving SOP for the escalation corridor due to increased challenges with capacity in the ED. However, they were confident that the current SOP was comprehensive for managing safe patient care.

Senior ED leaders told us they felt they were “carrying a lot of risk” in the ED. They recognised that being in escalation had become the norm rather than the exception and they described a culture of acceptance of the situation amongst the wider staff group. The ‘hospital full’ policy recognised that risk created by hospital capacity being outstripped by demand and blockages in the system was being held in ED and not spread across other divisions. However, the policy did not take into account capacity in ED was persistently in escalation and consider how risk could be shared across the divisions.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The department was aware of its performance, resilience and risk from a local dashboard, called the whiteboard, designed to provide live data throughout the day and night. However, this was only visible to managers within the department, hospital leaders, and those whose role was specifically related to the management of flow.

The nurse in charge of the ED manually completed a document to reflect the status of the escalation level of the department at regular intervals throughout the day with data taken from the white board and from the ambulance service’s dashboard. The nurse in charge would then escalate any concerns regarding capacity to the emergency practitioner in charge, and hospital leaders, so work could commence to increase capacity. This was a labour-intensive task that in other trusts was completed automatically through the use of information technology. Information for patients in the waiting area about expected length of waits for treatment was also generated manually. This task was given to the triage nurse who was only able to update the information when there was a lull in the number of patients accessing the service, this meant at busy times this information was not always reliable.

The trust had plans to improve patient notes which were a combination of paper and electronic notes. Senior leaders told us a new paper free patient notes system was due to be introduced in the ED in April 2024 as part of the trusts transformation process. Initially, the new electronic notes system would only be available in the ED.

Computers were password protected and quickly logged users out if they became inactive.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Senior leaders were able to demonstrate a commitment to creating a patient-centred organisation through engagement and involvement with patients, carers, the community, and stakeholders. They recognised the importance of obtaining feedback using a range of methods to provide them with information which could be used to influence change and improve services. To this end they launched a range of initiatives, including to recruit additional patient and carer representatives to become active members of the Speciality Patient Experience Groups and Patient and Carer Experience Panel. This was an improvement since the 2021 inspection.

We saw evidence that patient representatives sat on a number of meetings aimed at improving patient care and had also been involved in designing questions for the patient satisfaction survey. Leaders explained that when patients or family members had made complaints, they used the process to encourage them to join the team of patient representatives.

Leaders told us staff were engaged in designing SOPs for service delivery because of their specialist knowledge and day to day experience of the patient care delivered under the SOP. SOPs required sign off by senior management to ensure risk sat at an appropriate level. Staff were invited to provide feedback on the service, including through service improvement ideas, the staff survey, and through a bespoke app which could be accessed through a QR code.

Leaders told us about some of the changes to the service that took place as a direct result of feedback from staff including making changes to the skill mix of staff in some ED areas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Leaders gave evidence of improvements resulting from our last inspection, such as moving wash hand basins into easy reach of staff caring for patients and replacing flooring with non-porous vinyl.

We saw evidence that the practice educator team had successfully improved competency within the nursing and health care assistant staff group.

Medical staff told us their continued professional education was of a high standard, time for learning was protected and learning was delivered by local and regional specialists.

To speed up treatment for patients with chest pain staff designed a system for an electrocardiogram (ECG) to be performed as soon as possible after patients on foot who arrived with chest pains to assist in the early identification of heart conditions.