Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust

Princess Royal Hospital NHS Trust

Quality Report

Grainger Drive
Apley Castle
Telford
Shropshire
TF1 6TF
Tel: 01952 641222
Website: www.sath.nhs.uk

Date of inspection visit: 14-16th October 2014
Date of publication: 20/01/2015

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Princess Royal Hospital is part of Shrewsbury and Telford Hospital NHS Trust. They provide district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin, and mid Wales. Of the area covered by the trust, 90% is rural. A recently-built Shropshire Women and Children's Centre has opened at the hospital, and services for children across the county are provided at this one location.

We carried out this comprehensive inspection because the trust had been flagged as a potential risk on CQC's Intelligent Monitoring system. The inspection took place between 14 and 16 October 2014, and an unannounced inspection visit took place on 27 October.

Overall, this trust requires improvement. We found that services for children and young people, maternity and gynaecology, outpatients, and A&E services, were good. Critical care, surgery, medicine, and end of life care services, required some improvements to ensure a good service was provided to patients. We rated it good for caring for patients, but it requires improvement in providing safe care, effective care, being responsive to patients' needs, and being well-led in some areas.

Our key findings were as follows:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- The hospital was visibly clean and well maintained. Infection control rates in the hospital were lower when compared to those of other trusts.
- Patient's experiences of care were good, and results from the NHS Friends and Family Test were in line with the national average for most inpatient wards, but were above the national average for A&E.
- The trust had recently opened the new Shropshire Women and Children's Centre at the Princess Royal site. This had seen all consultant-led maternity services and inpatient paediatrics move across from the Royal Shrewsbury site. We found that this had had a positive impact on these services.
- The trust had consistently not met the national target for treating 95% of patients attending A&E within four hours. However, we saw at the Princess Royal Hospital that services were safe and effective, with adequate staffing, and the team were well-led.
- There was some good care delivered in the medical wards, but high staff vacancies and heavy reliance on bank staff were putting considerable pressure on the staff.
- The trust was not meeting the Core Standards for Intensive Care Units at the Princess Royal Hospital. We were concerned about nurse staffing levels, and asked the trust to look at the situation immediately. During our unannounced inspection we were assured to see that the trust had responded.
- The trust had recognised that end of life care was an area for development for them, and had recently started to make progress; however, our inspection found that there was still much more to be done. Whilst the care on the wards was good, the mortuary area was poor, and required improvement. We were concerned about the safety and effectiveness of the mortuary arrangements at Princess Royal Hospital in that the maintenance of this area was poor and it could not cope with the current demands placed on the service.

We saw several areas of outstanding practice, including:

- The hospital had outstanding safeguarding procedures in place. The safeguarding team had links in every department where children were seen, with safeguarding information shared across the trust.
- The hospital had an Independent Domestic Violence Advisor (IDVA). The post had been substantiated through funding from the Police Crime Commissioner, due to excellent outcomes recorded by the trust. We were told that referrals from the trust to the Multi-Agency Risk Assessment Conference (MARAC) had been endorsed as excellent practice by the Co-ordinated Action Against Domestic Abuse (CAADA). CAADA is a national charity supporting a multi-agency and risk-led response to domestic abuse.

Summary of findings

- The compassionate and caring dedication for end of life care within the renal service was outstanding, especially the development and introduction of the 'my wishes' document at the Princess Royal Hospital, for supporting people who had been diagnosed with an 'end stage' decision.

We raised some of the urgent issues at the time of our inspection and the trust has taken action to address the equipment staffing needs within critical care areas.

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

Importantly, the trust must:

- The trust must review the levels of nursing staff across A&E critical care, labour ward and end of life services to ensure they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that further service development and learning can take place.
- Ensure that staff are able to access mandatory training in all areas.
- Review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.
- Ensure that mortuary services are safe through maintenance of this area.

There were also areas of practice where the trust should take action:

There were also areas of practice where the trust should take action. These included:

- The trust should ensure that there is a designated safeguarding lead in the accident and emergency department.
- The trust should review the arrangements for visitors entering and exiting the labour ward to ensure that it does not impact on midwives workload and that in the event of an emergency, staff and patients can easily leave the department.
- The trust should ensure that the quality dashboard reports accurately reflect performance against targets at each site, and that thresholds are clear.
- The trust should review sustainability plans and budgetary support for end of life care.
- The trust should review arrangements for seven-day working in therapy and pharmacy services, to ensure wards and departments are supported over the weekends.
- The trust should ensure that medicines are held securely in surgical ward areas.
- The trust should ensure that the 'Butterfly Scheme' for dementia patients is rolled out and embedded across all wards in medicine.
- The trust should develop a strategy for the improvement and delivery of end of life care.
- The trust should review staffing and management structures for end of life care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The accident and emergency department at the Princess Royal Hospital required improvement to be protect people from avoidable harm. We saw that the majority of staffing levels were sufficient. However, there were some areas of inadequate staffing levels to provide care to patients. In particular, the department falls short with regards to paediatric trained staff, and does not have a paediatric-trained nurse on each shift. Equipment was visibly clean and maintained, with labels highlighting when the next service was due. There was adequate appropriate equipment available within all areas of the accident and emergency department. Staff received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately. Staff took the time to listen to patients, and explain to them what was wrong and any treatment required. Patient's dignity and privacy was respected at all times during our inspection. Staff were proud to work for the accident & emergency department.
Medical care	Requires improvement 	The medical care required improvement in ensuring that staff were aware of the safety data and incidents, so that steps could be taken to improve the service. Staff shortages were impacting on the quality of care provided, as staff supported agency staff. This also led to staff having difficulty in attending mandatory training sessions. Multidisciplinary working was widespread during core hours. The trust had not promoted seven-day working, and this was impacting on patient care and recovery. We saw that the introduction of the 'Butterfly Scheme' for the care of patients with dementia, had been initiated; this had been well promoted on the elderly care ward and stroke unit, but required further work to cascade to its full potential in all areas. We observed all levels of staff demonstrating a caring attitude towards their patients, treating them with dignity and protecting their privacy.

Summary of findings

However, we found that some patients were moved on to wards which were not part of the speciality dealing with their health problem due to delays in discharge processes.

Surgery

Requires improvement

Services were not always safe, as there were delays in getting equipment; intravenous fluids and medicines were not stored correctly; there was insufficient surgical cover after 5pm, and no acuity tool was used to determine safe staffing levels in real time, although the Safer Nursing Care Tool was completed quarterly to determine planned staffing levels. Audit data demonstrated that some patient outcomes were not as good as the England average, and there was a lack of competency assessments for staff. There were no formal arrangements for physiotherapy cover for the trauma ward, which was operated on a volunteer basis.

Services were caring; we saw positive staff interactions with patients, and staff demonstrated genuine empathy and rapport with patients.

Surgery was not always responsive, as it failed to meet treatment times for some specialities. Patients, including children, could be kept waiting in day surgery before being found a bed, and moves between wards also occurred. Services were not well-led, due to a lack of vision for the service in some areas, and change of leadership and reorganisation. Staff wanted to ask questions of board level managers, and felt they had been stopped from doing so.

Critical care

Requires improvement

Critical care services were found to require improvement overall. There were insufficient, suitably skilled and experienced staff on the unit, which represented a significant risk to patients. When we highlighted the staffing shortfalls to the trust, they took immediate action to ensure that sufficient and appropriate nursing staff were available to care for patients in the intensive care unit (ICU), high dependency unit (HDU) and the coronary care unit.

Critical care services were obtaining good quality outcomes, and patients received treatment that was based on national guidelines. The critical care service staff were caring and compassionate, and we judged that this domain was good.

Summary of findings

The general capacity of beds in the hospital was a challenge. Bed capacity had also impacted on critical care services, both in the availability of the beds within critical care, and also in delays in discharging patients to other wards. Improvements were required to the leadership of the critical care services, to ensure that the management responded appropriately to staff, and that the service provided met national guidelines.

Maternity and gynaecology

Good

Overall, the services for women in maternity and gynaecology were good; however, some improvements are required in order to keep patients safe. These include reviewing the number of staff available, as currently, staff are moved within the unit to meet the demands of patients, sometimes leaving the staff cover on specific areas thin. The incident reporting, investigation process, as well as shared learning, were inconsistent.
The service did not have a vision beyond the recent restructure or additional staff recruitment. We noted that data reported and monitored could not be relied upon, and the dashboard would benefit from broadening the areas that it reported on.
However, women we spoke with were largely satisfied with the care they had received, and found staff to be helpful. Staff felt supported by local management, but not by senior management.

Services for children and young people

Good

Services for children and young people were found to be good. Children received good care from dedicated, caring and well trained staff, who were skilled in working and communicating with children, young people and their families. There were processes in place for children's safeguarding, and concerns were identified and referred to the relevant authorities.
The trust had provided good flexible staffing levels, an adequate skill mix, and had encouraged proactive teamwork to support a safe environment. There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices.
Outcomes for patients were good, and treatment was in line with national guidelines. There were clear strengths in specialist areas in treating

Summary of findings

children. Staff felt valued, and had clear lines of communication though the trust. Staff felt confident in raising concerns, and felt listened to regarding ideas to improve services.

End of life care

Requires improvement

End of life care required improvements in all areas, except for caring, which was good. The service was not safe, because we had concerns about a number of aspects of the mortuary provision. Staffing levels of nurses and medical staff in palliative care were not sufficient. Staff were not provided with mandatory training in end of life care.
The trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. The service was not responsive, because there was no formal strategic plan for the service delivery of end of life care within the trust.
The service was not well-led. We found that there was oversight by senior management and members of the executive team with regards to end of life care that required improvement. We saw many examples of compassionate care delivered with respect.

Outpatients and diagnostic imaging

Good

Overall, we rated this service as good. During the inspection we did identify a small number of areas where the trust could improve. Outpatients and diagnostic services were safe; the trust had prioritised statutory training; however, refresher mandatory training had not been completed by the majority of staff. Staffing levels were in line with national guidance.
We saw good practice and effective, compassionate care. Patients were very complimentary about all the staff they had come into contact with. We found that clinics followed national guidance and good practice relative to their individual specialities.
Diagnostic services at the Princess Royal Hospital did not have access to a screening room which was suitable for paediatric services. We saw how a patient who might have benefited from appropriate screening equipment had to undergo an alternative treatment. Whilst the alternative had been safe and appropriate, staff told us that the method used would not have been their first choice had they had an option.
Services were managed well at a local level.

Requires improvement

Princess Royal Hospital NHS Trust

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Princess Royal Hospital NHS Trust

The Princess Royal Hospital in Telford was built in the late 1980s. It merged with the Royal Shrewsbury Hospital in 2003, when the Shrewsbury and Telford Hospital NHS Trust was formed.

The Princess Royal Hospital provides a wide range of acute hospital services, including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. The hospital is also the main centre for hyper-acute/acute stroke services, inpatient head and neck surgery, and inpatient women's and children's services.

The trust has a relatively new executive team. The finance director has been in post since 2011. The chief executive and chief operating officer since 2012, and the director of nursing and the medical director are the most recent appointments, in 2013. The chair has also been in post since 2013.

Shrewsbury and Telford Hospital NHS Trust had been inspected 11 times since its registration with the CQC in April 2010. The hospital was last inspected in April 2013, and was found to be non-complaint with a number of the Essential Standards, and had compliance actions to continue to improve.

We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it represented a high risk according to our new Intelligent Monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations.

The inspection team inspected the following eight core services:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology services
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing and Patient Experience, Royal Surrey County Hospital NHS Trust

Team Leader: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team of 35 included CQC inspectors and a variety of specialists: medical consultant, surgical consultant, consultant obstetrician, consultant paediatrician, consultant anaesthetist, junior doctor, board level nurses, modern matrons, specialist nurses, theatre nurses, emergency nurse practitioner,

supervisor of midwives, student nurses and a paramedic and four 'experts by experience'. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), NHS Trust Development

Detailed findings

Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the two local Healthwatch organisations.

We held two listening events, in Telford on 14 October 2014, when people shared their views and experiences of both hospitals. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out an announced inspection visit on 14–16 October 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We also carried out an unannounced inspection on Monday 27 October 2014

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Shrewsbury and Telford Hospital NHS Trust.

Facts and data about Princess Royal Hospital NHS Trust

The annual turnover (total income) for the trust was £314 million in 2013/14. The trust surplus (deficit) was £65,000 for 2013/14.

The Princess Royal Hospital has 310 beds, across 29 wards, and employs over 2,500 staff.

During 2012/13, the Princess Royal Hospital had 30,503 inpatient admissions, 263,115 outpatient attendances, and 55,160 attendances in the emergency department. Between May 2013 and April 2014 4,721 babies were born at the trust.

Bed occupancy for general and acute care across the trust was 90.4% between April and June 2014. This was above both the England average of 87.5%, and the 85% level, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital. Adult critical care was also higher than the England average; 90% against the average of 85.7%. Maternity was at 55% bed occupancy – lower than the England average of 58.6%.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Inadequate	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We do not currently rate effectiveness in outpatients.

Urgent and emergency services

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

Information about the service

The accident and emergency department (A&E) at the Princess Royal Hospital provides a 24-hour, seven-day a week service to the local area. The department saw 55,160 patients across the trust, between April 2013 and March 2014. The trust's performance with regards to the four hour waiting times has been consistently below the England average waiting time between April 2013 and August 2014.

The A&E department is a member of a regional trauma network, and the hospital provides a hyper-acute stroke service. Patients present to the department either by walking in via the reception, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area, and a children's A&E service.

During our inspection, we spoke with clinical and nursing leads for the department. We spoke with three members of the medical team, and seven members of the nursing team, including lead nurses for various areas including children's services, falls and major incident management. We also spoke with eight patients, and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the A&E department.

Summary of findings

The accident and emergency department at the Princess Royal Hospital required improvement to be protect people from avoidable harm. We saw that the majority of staffing levels were sufficient. However, there were some areas of inadequate staffing levels to provide care to patients. In particular, the department falls short with regards to paediatric trained staff, and does not have a paediatric-trained nurse on each shift. Equipment was visibly clean and maintained, with labels highlighting when the next service was due. There was adequate appropriate equipment available within all areas of the accident and emergency department.

Staff received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately. Staff took the time to listen to patients, and explain to them what was wrong and any treatment required. Patient's dignity and privacy was respected at all times during our inspection. Staff were proud to work for the accident & emergency department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The accident and emergency department at the Princess Royal Hospital required improvement to be protect people from avoidable harm. We saw that the majority of staffing levels were sufficient. However, there were some areas of inadequate staffing levels to provide care to patients. In particular, the department falls short with regards to paediatric trained staff, and does not have a paediatric-trained nurse on each shift.

Staff were aware of the challenges within the department, regarding service provision against demand, and pro-actively managed this within the multidisciplinary team. The A&E department had limited space to expand, but care was provided in a safe environment. We looked at staff training records, and all staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around the trust's policies and procedures.

People that used the department services were protected from abuse and avoidable harm, and people told us during our inspection that they had all their questions answered and felt involved in making decisions about their care.

Incidents

- The trust reported eight serious incidents (SI), relating to both the Princess Royal Hospital and the Royal Shrewsbury Hospital, to the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS), relating to the accident and emergency departments between March 2013 and March 2014. Four of these serious incidents related to a delayed diagnosis.
- We asked staff if they reported incidents and had knowledge of the reporting system. Staff told us that they knew how to report incidents via the internal hospital system, and that the feedback from reporting incidents was good, and was completed by the department managers. Staff understood their responsibilities to raise concerns internally and externally to the trust.
- We spoke with senior nursing staff, who told us about evidence of learning from incidents. For example, there has been a change within the children's A&E waiting area; there is now a separate waiting area with privacy windows, which is secured via a pin coded door, and which is available to parents and carers.
- During our inspection we pathway-tracked an incident report involving a person who used the department services. We saw that the incident had a thorough and robust review following an investigation. The person affected had been given an apology, and informed of the actions taken as a result of the incident.

Cleanliness, infection control and hygiene

- During our inspection, we observed staff using personal protective equipment, whereby all staff were witnessed to be wearing gloves where required, and washing their hands between patients, and using hand-sanitising liquid.
- Treatment rooms were deep cleaned after any patient with a queried infection was admitted to another area or discharged, and the department has cubicles with doors that could be used.
- The trust's infection rates for C.difficile and MRSA infections lie within a statistically-acceptable range for the size of the trust.
- We noted during our inspection that there was a specific room available which was designed with a correct negative air flow system. (The air pressure in the room under negative pressure is lower than outside, so that contamination from the room does not flow out into surrounding areas. The negative pressure environment is used to protect others from patients being nursed in isolation because they have a contagious disease.) The room was also fitted with the correct high efficiency particulate air (HEPA) filter to remove viruses and bacteria, and was changed on a regular basis.
- Clinical areas were segregated from storage areas, and we found that the handling, storage and labelling of chemicals for the use of cleaning conformed with the control of substances hazardous to health (COSHH) requirements.
- The A&E department at the Princess Royal Hospital had designated housekeeping staff employed specifically for the department. We spoke with the housekeeping staff,

who told us that they enjoyed working in the same area, as it allowed continuity in managing the cleanliness of the department, and they were proud of the ownership of their responsibilities which the system gave them.

Environment and equipment

- The resuscitation area was visibly clean, with ample space for resuscitation teams to care for each patient as required. Resuscitation equipment was available, and clearly identified, whereby equipment trolleys followed a system that adopted an airway, breathing and circulation management approach within each resuscitation bay.
- Each resuscitation bay had a full anaesthetic provision available. The anaesthetic machines were maintained and checked daily by an operating department practitioner (ODP). The ODP signed off the checks on a formal record. We looked at these records, which demonstrated that thorough consistent daily checks were carried out.
- There was a specific area for children and neonatal resuscitation, with an appropriately-equipped equipment trolley.
- During our inspection we noted that there were resuscitation trolleys within both the majors and minors treatment areas. The resuscitation trolleys were checked daily, and we saw records which demonstrated that this had been carried out.
- Treatment cubicles were clean and bright, with diagnostic equipment available in each cubicle.
- We looked at various pieces of equipment across all areas within the A&E department. We found equipment to be consistent with regards to scheduled servicing. This was identified through the trusts internal service stickers on each piece of equipment.

Medicines

- During our inspection we checked the records and stock of medication, including controlled drugs, and found correct and concise records, with appropriate daily checks carried out by qualified staff permitted to perform this task.
- We looked at patient prescription records and charts, which were completed and signed by the prescriber and by the nurse administering the medication.

Records

- We looked at five sets of accident and emergency clinical notes during our inspection.
- All of the notes we looked at had completed observations taken, with regular re-assessments, which were recorded.
- During our inspection we observed that accident and emergency notes were kept safe and secure. Notes were easily defined between clinical observations and nursing/medical notes.
- We saw within the accident and emergency notes that risk assessments were undertaken in the department when patients were in the department for some time. (It is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed.)
- We saw that care and comfort charts were fully completed for patients within the department.

Safeguarding

- The accident and emergency department did not have a designated safeguarding lead within the department. The senior manager told us that they have a safeguarding lead for the hospital and it is this person who they work with on all safeguarding concerns. We looked at safeguarding referrals, and found that all had been completed in an acceptable, timely manner.
- Safeguarding concerns were reviewed at a senior level, to ensure that a referral had been made to the local authorities' safeguarding team.
- We looked at training records, and saw that all nursing and medical staff had undergone mandatory safeguarding training to an appropriate level.
- The staff we spoke with were aware of how to recognise signs of abuse, and the reporting procedures in place within their respective areas.

Mandatory training

- We looked at the records of mandatory training for all nursing and medical staff, 77% of staff were recorded as up to date. There was also an element of supplementary training, which included major incident preparedness and specific subjects, such as trauma-related injuries.
- Mandatory training was provided in different formats, including face-to-face classroom training and through e-learning (e-learning is electronic learning via a computer system).
- We spoke with staff about their training, and one person told us "training and development is encouraged and the lecture room is regularly used". Another nurse told us "peer to peer learning is encouraged".

- We saw that there was an overlap period after the lunchtime handover, and the nursing staff were able to use this time to facilitate training time across all nurse grades.

Management of deteriorating patients

- We observed that the department operates a triage system of patients presenting to the department either by themselves or via ambulance, and they are seen in priority dependent on their condition.
- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert), so that an appropriate team are alerted and prepared for their arrival. We looked at an example of a completed pre-alert, and found that it contained all of the information required for the team alerted.
- We spoke with an air ambulance paramedic, who transported a patient via air landing at the hospital during our inspection. They told us that they do not come to the A&E department that often, as they are not a tier 3 unit in trauma network; but when they do, the department worked well with the air ambulance, and there was an evident team approach in managing a deteriorating patient.
- Nursing handovers were comprehensive and thorough, covering elements of general safety, as well as patient-specific information.
- The accident and emergency department operates a national early warning score (NEWS) alert system, to monitor the condition of patients and alert them to any changes. The NEWS system is based on a simple scoring system, in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in, hospital.

Nursing staffing

- Information provided by the trust indicated that the establishment for the accident and emergency department was not operating at the required whole time equivalents (WTE), with a number of qualified nurse posts vacant. Senior staff acknowledged that they were not meeting the RCN 'BEST' policy to understand their staffing needs, and they were actively looking at this policy.
- We saw that a recent skill mix review had taken place, and was authorised, with staff being implemented into place within the department. However, we were told that there are numerous nursing posts becoming vacant, and this is causing concerns with regards to specific recruitment into the A&E department, with trained A&E nurses. The vacancy rate for registered nurses (bands 5 and above) at Princess Royal Hospital in July 2014 showed that there was just over 1% vacant posts whilst bands 2-4 were over 15%.
- The department did not have a sufficient whole time equivalent of nurses with specific paediatric qualifications working within the paediatric A&E. We saw that the department operates with one senior paediatric trained nurse alongside 0.8 of whole time equivalent (WTE) and a dedicated solely trained registered children's nurse (RCN). When they were on shift they would be assigned to the paediatric service within accident and emergency, and would be supported with other nurses. Current guidance form the Royal College of Nursing states that there should be one paediatric nurse on each shift. This guidance has been in place since 2003.
- We were told by a senior nurse that all staff also receive paediatric immediate life support. Should a neonatal emergency occur within the A&E department, a neonatal nurse specialist team carry a bleep and attend the A&E department to support.
- We observed that there was a professional handover of care between each shift.
- The accident and emergency department is very reliant on bank and agency staff, which can pose a risk to safety. However, these staff received local induction prior to starting their shift, and the department often saw the same bank and agency staff, which improved continuity.
- We spoke with senior A&E managers, who told us that there were plans to introduce advanced nurse practitioners (ANPs), but due to a lack of ability to provide consultant support, this has not happened. We were told that the A&E department is currently recruiting four emergency nurse practitioners (ENPs), and this service will be running from April 2015 with two ENPs.

Medical staffing

- 23% of medical staff are consultants, this is in line with the England average.
- Consultant grade doctors are present in the department from 8am until 8pm. There are middle grade doctors and junior doctors overnight, with an on-call consultant system.

Urgent and emergency services

- There was a higher than the England average use of middle grade doctors, which was 32% compared to an England average of 13%. This meant that there was an ability to make patient care decisions by doctors with regards to admitting and discharging patients in a timely manner.
- We looked at the doctor's rota and saw that the locum middle grade doctor use was consistent, in using the same doctors who had received the trust induction programme, and were familiar with the department and protocols.
- The medical staff work across both the Princess Royal and the Royal Shrewsbury Hospitals on a rota basis.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We found that the A&E department was performing below the national average in the College of Emergency Medicine audits and did not appear to be using this to improve services within the department. However the A&E used evidence-based guidelines – for example, there were a number of care pathways in the department, for patients with specific conditions to follow, such as the stroke and sepsis pathway.

The department took part in national College of Emergency Medicine audits. The majority of results were worse than other trusts and the results had not been used to assess the effectiveness of the department.

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that as NICE guidance was issued, they made sure that any guidance relevant to the A&E department was implemented, and that staff were aware of the requirements. NICE guidance was discussed at governance meetings which senior staff attended.

Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of, and reported they used. There were a range of accident and emergency protocols available, which were specific to the accident and emergency department.
- Further trust guidelines and policies were within the accident and emergency department; for example, sepsis and needle stick injury procedure. We saw treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We observed patient care being provided which was in accordance with the National Institute for Health and Care Excellence (NICE) guidelines, and both medical and nursing staff demonstrated an underpinning knowledge of the NICE and College of Emergency Medicine (CEM) guidelines available.
- We found reference material to the College of Emergency Medicine (CEM) standards, and these were available to staff.

Care plans and pathway

- There was a clear protocol for staff to follow with regards to the management of stroke, fractured neck of femur, and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- We looked at three nursing care plans and these were compiled fully, with all admission charts completed. We also spoke with two patients, who told us that they were involved in their admission, and informed of all plans of their care, and the pathway that they went through was fully explained to them.
- People had their needs assessed where required, which was implemented into a care plan at an early stage. We looked at supportive internal documents which demonstrated that this was monitored on a regular monthly basis to ensure compliance, and that care was delivered in line with evidence-based practice, such as National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) guidelines.

Nutrition and hydration

- The department made regular comfort rounds 24 hours a day, seven days a week, and it was observed during our inspection that patients received regular drinks where appropriate.

- We saw from records that charts within patients notes were completed, with fluid monitoring intake and output.

Outcomes for the department

- We were informed that the department took part in national College of Emergency Medicine audits, and the majority of results were worse than other trusts and within the lower England quartile. We could not see evidence that the results had been used to assess the effectiveness of the department.
- The College of Emergency Medicine recommends that the unplanned re-admittance rate within seven days for accident and emergency should be between 1-5%. The national average for England is around 7%. The trust has consistently performed well against unplanned re-admittance since January 2013. Their rate in May 2014 was 5.5%.

Competent staff

- Appraisals of nursing staff were undertaken, and staff spoke positively about the process and that it was of benefit to them.
- We looked at the skills of staff, and saw that staff had the right qualifications, skills, knowledge and experience to provide care to people. We spoke with four members of staff, who explained that they received clinical supervision within their roles, and this was on a regular monthly basis, or where required.
- We saw records that demonstrated that 100% of both medical and nursing staff were revalidated in basic, intermediate and advanced life support.
- Staff told us that they felt they would benefit from further support in caring for a dying patient and their family and friends, and this was an area of weakness in the department

Multidisciplinary team working and working with others

- We witnessed comprehensive multidisciplinary team (MDT) working within the accident and emergency department. Medical and nursing handovers were undertaken separately.
- Nursing handovers occurred twice a day. Medical handovers occurred twice a day and were led by the consultant on the A&E floor.
- Staff we spoke with were aware of the protocols to follow, and key contacts with external teams. We witnessed a professional patient experience, from their transition from the care of the ambulance service into the care of the accident and emergency staff.
- During our inspection we witnessed staff within the A&E department working well and cohesively with other departments, both internally and externally to the hospital. For example, theatres, radiographers, and ambulance staff.
- Information was shared, where appropriate and authorised, with others, to enhance the care and experience that patients received in the department.
- The department holds monthly clinical governance meetings, whereby incidents, incident outcomes and learning from incidents, are regular agenda items. These meetings also include mortality and morbidity as items on the agenda. Both clinical and nursing staff attend these meetings.

Seven-day services

- There was a consultant out-of-hours service provided via an on-call system.
- Accident and emergency offered all services where required, seven days a week.
- We were told by senior staff within the A&E department that external support services, such as mental health provision, are limited out of hours, and it often proves difficult at weekends, which has an effect on patient discharges and care packages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured that the patient was safe, and then undertook a mental capacity assessment.
- We saw the accident and emergency training data, which showed that all nursing and medical staff had undergone their mental capacity training. We also spoke with nurses, who informed us that they had attended training, and found it educational and of benefit, with quality teaching.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being

carried out. In particular, we heard a doctor introduce themselves to a patient and explain the tests they wished to complete, and obtain the patients consent prior to carrying out the procedure.

- We spoke to patients during our inspection who told us that they all had been asked to give their consent, and that all staff were very polite and professional.

Are urgent and emergency services caring?

Good

Evidence collected and supplied to our inspection, and obtained from speaking to patients, provided us with sufficient assurance that the department at the Princess Royal Hospital was providing a consistently caring service.

The department had worked hard to increase the Friends and Family Test response rate. During our inspection we did find Friends and Family questionnaires out in view within the treatment and reception areas.

We were witness to many episodes of caring interaction during our visit, with feedback from individual patients and relatives which was universally positive. Observations of staff showed that people were treated with compassion and kindness in the department. Patients confirmed this when we spoke to them.

Patients' privacy was respected and their confidentiality maintained. Most patients in the department were assessed in private, and this included patients being seen by the nurse triage team in an assessment room within the waiting area.

Compassionate care

- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring, compassionate attitudes towards patients, which were also respectful to both patients and relatives.
- Nursing and medical staff ensured that privacy was maintained, and dignity respected, when carrying out physical examinations and providing care, with curtains pulled or doors closed at all times.
- The trust can be seen to be performing better than the England average for the Friends and Family Test (FFT). This is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used, and offers a range of responses. The FFT highlights both good and poor patient experience.
- We spoke with four patients about the care they had received. One patient told us "I have received excellent care and attention from the nurses". Another person told us "I went to the X-ray department very quickly and my X-rays were back quickly as well, it was a quick and efficient transfer".

Patient understanding and involvement

- Patients told us that they felt informed about their patient journey, and that staff were responsive. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- We spoke with patients and relatives, and they told us that they would recommend the service to family and friends.
- The department arranged the nursing staff into teams that looked after specific areas, which facilitated a better patient experience, with having a named nurse looking after them whilst in the accident and emergency department.
- We spoke with a patient's relative, who told us that they were impressed with the information given to their relative (patient) about their condition. The patient wanted to know specific information about their condition, and the nurse ensured that they went to find the relevant specialist information and returned to inform the patient, in a caring manner and with a calm approach, and that the patient understood everything.
- Patients were involved in the care and in taking decisions when they were able to be. One patient we met said that they had been able to explain all their symptoms, and answer and ask questions. They said nothing had been done or given to them without their consent. They said they did not feel that they were asked to do anything, or follow a course of action, without knowing why this was the best option for them. They said that they were given alternatives, and the risks and benefits of all options. Staff knew the importance of gaining valid, informed consent for patients, and involving them in all decisions.

Urgent and emergency services

Emotional support

- There was limited training available for staff to be able to support patients and relatives, and staff used their own and colleagues experience to provide emotional support.
- There was emotional support to patients and their relatives. During our inspection we witnessed a patient receiving end of life care, and the nursing and medical staff ensured that as much appropriate care was also provided to the relatives who were present as well.

We saw that people's independence was respected and supported, which enabled people to manage their own health, care and well-being.

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

Requires improvement

Trusts in England were tasked by the Government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the accident and emergency department. The Shrewsbury and Telford Hospital NHS Trust was consistently not meeting this target. The trust had struggled to maintain the 95% target, and many times it had been worse than the England average for the period from August 2013 to August 2014. The lowest was 88% in January 2014.

The department requires improvements to be made to ambulance waiting times, which were worse than the national average, and to the time taken to treat patients both within four hours and between four to 12 hours of entering the department.

The department had surges of activity which occur on a regular and potentially anticipatory basis. The department struggled with space, equipment and staffing in coping with capacity issues with surges of activity. However, we saw that the nursing and medical staff were trying to achieve the best they could, with a department that had outgrown itself.

There were regular occurrences of ambulances stacking and waiting to handover within the department, but the department had a good working relationship with the local ambulance service to take a pro-active approach in managing these occurrences, and the ambulance service attended the department in support.

The A&E department had more of a reactive than pro-active approach to episodes of peak demand. During our inspection we saw a number of patients arrive via ambulance, but we witnessed that no one monitored this via the electronic in-bound screen, which identifies ambulances on their way into the department. This affected the availability of cubicles to take a handover from the ambulance crews.

Meeting the needs of all the people

- We spoke with staff within the department about who, within the site team, should be contacted when there were delays to patient flow. Not all staff were aware of the protocol to follow.
- There were information leaflets available for many different minor injuries. These were available in all of the main areas. Posters and information were available within the reception area, which signposted people to other appropriate care pathways, and gave contact information for services which included family support, drug rehabilitation and vaccination services.
- We saw that the department had champions who led on specific areas to facilitate individual needs, such as learning disabilities, mental capacity, dementia and falls.
- The facilities in the children's emergency department enabled effective treatment delivery of care for children. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) states that there should be one or more child- friendly clinical cubicles or trolley spaces per 5,000 annual child attendances. Children should be provided with waiting and treatment areas that are audio/visually separated from the potential stress caused by adult patients. There was a children's emergency department within the main emergency department.
- We observed that patient privacy and dignity was respected, and that ambulance crews were able to hand over the care of patients to A&E staff in an area where patient confidentiality could be respected.
- We witnessed staff providing patients and relatives with emotional support. The A&E department at the Princess Royal Hospital provided a relatives room. We looked at

the suitability of this room, and found it to be inadequate, with a lack of any appropriate information. The comfort of the room was limited to due to its very small size.

Access and maintaining flow through the department

- The department operates a triage system of patients presenting to the department, either by themselves or via ambulance, and patients are seen in priority, dependent on their condition.
- The trust was performing below the England average with regards to handover of patient care from the ambulance crew to the accident and emergency department, and there were consistent long ambulance delays, with waiting times over thirty minutes.
- The pressure on bed space meant that waiting times in A&E were often not meeting targets, and this impacted upon patient care. The A&E department had regularly breached the Government four-hour waiting target for 95% of patients to be seen and discharged from the department (to home or a ward, for example). The lowest was 88% in January 2014.
- Staff told us that the portering service was not effective. Staff said the service was "terrible" and "not working". A number of staff said that this was one of the things that could be solved so easily, but caused some of the biggest frustrations. This was due to the trust changing to a central requesting system for portering services, which logged each request and then allocated them on an individual basis.

Complaints handling (from this service) and learning from the feedback

- The A&E department advocates the Patient Advice and Liaison Service (PALS), which is available throughout the hospital.
- Information was available for patients on how to make a complaint, and how to access the Patient Advice and Liaison Service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- We were told that learning from complaints was disseminated to the whole team, in order to improve patient experience within the department. Complaints were analysed at the root cause.
- Patient Advice and Liaison Service leaflets were available throughout the department, and it was clearly explained to people in an open manner, as to how to make a complaint, and the process that a complaint takes with a timeline.

Are urgent and emergency services well-led?

Good

The leadership within the accident and emergency department at the Princess Royal Hospital was sufficiently matured to ensure that patient care, experience and flow through the department was assured, and staff of all grades were supported in their work.

Universally throughout the department, there was an acceptance of change. The staff we spoke with demonstrated an attitude of commitment. There was a clear demonstrable respect within the teams for the senior nurses and the decisions that these nurses made in the day-to-day running of the department. We saw a good ethos of team working, and morale was good

Vision and strategy for this service

- The department was aware of its wider risks. Risks were discussed at the monthly clinical governance meetings. The existing risks were reviewed, and new risks were agreed to be added to the risk register. There was a comprehensive and clear action plan for the A&E. This identified areas of concern, and actions to be taken to address these concerns. The staff responsible for the actions were identified, and a completion date was set.
- The future vision of the department was unsure, but it was very evident that the staff we spoke to, who included senior nurse managers of the department, encompassed the need to change to deliver a service to the local community and beyond.
- The perceived threat of closure had affected the vision of the staff we spoke to, but they demonstrated motivation, which spurred staff on to show the departments strengths and abilities.
- The trust had a lack of vision in the promotion of the best practices across both accident and emergency departments; the two A&E departments worked very differently, although best practice would demonstrate

streamlining and improving patient experience. For example, the initial triage system for walking patients consists of two different systems within one trust, and is open to interpretation with regards to the commencement of the four hour waiting time; a patient walking into the A&E department at the Princess Royal Hospital takes a ticket, waits to be seen by the initial triage nurse, who can take a considerable amount of time at high periods of demand, and once seen, the patient then books in with A&E reception. This process is not in place at the Royal Shrewsbury Hospital.

Governance, risk management and quality measurement

- Monthly departmental governance meetings are held. We were provided with minutes of the previous meetings held over the past six months.
- There was a set agenda for each of these meetings, with certain standing items, such as incidents, complaints, risk, staffing and training. The meeting minutes showed good open and honest discussions of, for example, complex cases, where not everything worked as it should have done.
- Within the minutes, the top risks were discussed, including what was being done to mitigate the risks.
- We spoke with staff about quality indicators, and staff had a demonstrable knowledge of clinical and performance indicators; senior staff quoted performance figures when asked and knew how the department was performing compared to other departments.
- We saw that there were monthly performance meetings held between the A&E senior nurse manager, operations manager, human resource department, matron and finance, with specific focus on the A&E department function. We were told by the A&E senior nurse manager that these meetings are positive and beneficial, with an open and informal approach.

Leadership of service

- There was an evident departmental team, which was respected and led by the senior nurses and A&E managers, who strived for continuous improvement to drive the department forward.
- During our inspection we saw that the matron was very much engaged with the department, and got involved in supporting the department in a focused manner.
- We were told that the operations manager was visible within the department, and was approachable to open discussion to resolve issues.
- We spoke with the emergency department nurse manager, who was a long standing member of staff, and it was very evident that they had an ethos of leading by example, and a desire to provide a first class service of which they could be proud.
- All staff we spoke to said that they felt well supported. A nurse we spoke with, who had recently joined the department, said that the team worked well together, supported each other and made them feel very much part of the team straightaway.

Culture within the service

- During our inspection it was evident from speaking with staff that the department created a culture which was centred on the needs and experiences of people who use the services.
- Staff told us that they felt respected and valued as part of a large busy team, and that the team's vision and values were consistent with the department's values of providing patient-centred care.
- We observed a culture of staff working collaboratively, and the management within the department encouraging an appreciative and supportive working ethos amongst staff for which staff felt respected and valued.

Public and staff engagement

- Staff told us that they were always engaged with patient experiences.
- A member of staff told us that they felt staff were told about patient complaints.
- Other staff we talked with said that the department was often so busy, but this was one of the areas that they had time to be told about. Staff told us that they were very well informed.
- During our inspection we saw information available in reception aimed at people who use the services, to encourage participation and involvement, so that people could get actively engaged and have their views reflected in the planning and delivery of services provided within the accident and emergency department. For example, suggestion boxes and cards were available; there were also banners displayed, advising how to 'get in touch'.

Urgent and emergency services

Innovation, improvement and sustainability

- All the staff that we spoke with were knowledgeable and aware of the priorities for the department.
- Staff were provided with updates on any changes or amendments to the department's priorities, and performance against those priorities.
- We saw evidence of staff innovation that was put into practice and owned by the department as a team effort. For example, a nurse was identified as having an interest and the qualifications to provide training for the department. This nurse now provides internal department training, which has improved the knowledge base of staff, and the ability to cover individual specific subjects, such as major incident preparedness, trauma and minor injury assessment.
- We were told that there are specific courses available to improve management qualifications and training through the human resources department.
- During our inspection we observed, across all of the A&E team, that staff had a desire to drive through innovation, and develop new ideas to improve the service. These ideas are put forward, and when we spoke with staff, one person told us that they had left the department previously and had subsequently returned, as they missed the department and support they received. Another nurse told us "I am very proud to work at this A&E department, it takes time to be accepted at Shrewsbury Hospital but here I was welcomed straightaway as part of the team".

Medical care (including older people's care)

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

Information about the service

The Princess Royal Hospital Telford provides cardiology, gastroenterology, endocrinology, neurology, acute stroke and stroke rehabilitation services. There are 185 inpatient medical beds available.

Patients are admittedto the acute medical unit (AMU) on a short stay basis after direct referral from their GP or from the Emergency Department. Patients are either discharged directly from AMU or transferred to a specialised ward within the hospital.

We visited seven wards and the AMU. We spoke with 17 patients and 26 staff. We observed staff interacting with patients on the wards.

Summary of findings

Medical care at Princess Royal Hospital required improvement.

Each ward displayed their safety data on a quality board but not all relevant data was included. The introduction of the quality boards had been welcomed by staff, but required embedding for a uniform approach across all the wards.

On the whole we found the wards were clean, well maintained and tidy. However, in several ward areas we observed poor infection control techniques relating to cannula care. Policy and procedures were not being followed and this was brought to the ward manager's attention.

Staff shortages were impacting on the wards performance. Ward staff were being supported on most shifts by agency and bank staff. Staff raised concerns with us about the quality of some agency staff which they felt increased the pressure on them and had an impact on morale. Some ward managers but not all, had ensured that trained agency staff had completed the trust based competency tests. It had been acknowledged by the trust that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. There were currently three trust funded vacancies.

Medical care (including older people's care)

Staff had not been released to attend mandatory training. Attendance levels for mandatory training were noted to be exceptionally poor in most areas in medicine; some as low as 5%.

The trust had not promoted seven-day working and this was impacting on patient care and recovery.

We saw that the introduction of the Butterfly Scheme for care of patients with dementia had been initiated but this required further work to cascade to its full potential in all areas.

The trust was aware that safety thermometer data had shown a high number of pressure ulcers and falls recorded in medical care. There was evidence that actions had been taken to reduce harm.

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

Are medical care services safe?

Requires improvement

The medical service requires improvement to ensure the safety of patients. Improvements were required to address pressure ulcers, falls and mandatory training attendance. Although improvements were noted in the high levels of reported pressure ulcers and ward-based falls, some of the initial cause was insufficient patient observation and care by the nursing staff. The average turnover of staff for medicine was 11.78%, which was above the trust average.

These staffing issues had resulted in poor attendance by substantive staff at mandatory training, as substantive staff were unable to be released from the wards. Staff reported that on occasions, when they did attend training, it had been cancelled due to overall low staff attendance. We were told by several ward managers that they had progressed with training their staff on the wards rather than them leaving the ward, to achieve a higher mandatory training percentage, and to ensure that their staff were updated.

The ward and patients areas were visibly clean and tidy. We saw hand hygiene policies adhered to, and staff wore protective clothing when required.

Resuscitation trolleys were accessible on each ward, and had been checked and signed as 'in order' on a daily basis, as per trust policy.

Infection control issues were identified regarding cannula care; on several occasions we observed the trust policy and procedure not being followed.

Incidents

- Serious incidents were investigated through a root cause analysis (RCA) process, and an action plan for improvement was developed. 37 serious incidents were reported for the Princess Royal Hospital.
- There were 31 serious untoward incidents reported to the Strategic Executive Information System (STEIS) for the hospital. The majority related to grade three or four pressure ulcers, and falls with harm.The trust reports both avoidable and unavoidable pressure ulcers onto this system for transparency.

- Action plans were implemented by the appropriate care groups, and monitored for completion within identified timeframes through governance groups. Trust-wide learning was shared through the clinical governance executive committee.
- Trust-wide learning was shared through the clinical governance executive committee, and through tools such as the safety bulletin, INJEKTION, a new publication which staff were proud to use to demonstrate areas of improvement through learning from incidents. We did not see evidence of this bulletin at the Princess Royal Hospital.
- Staff told us that they were aware of how to report incidents and encouraged to do so, but on occasions they did not get any feedback, which did not promote learning.
- The trends that were highlighted through care audit results were monitored, and action taken to improve any issues that were identified. For example, hand hygiene compliance had improved in all areas. Staff were observed and spot checked by the ward sister to ensure that they were following the trusts hand hygiene policy.
- Doctors told us that they rarely reported incidents, but that nurses reported any situations which they may have been involved with.
- Matrons told us that they were encouraged to attend the mortality and morbidity meetings relevant to their area, and that they then fed back details to the ward staff involved.

Safety thermometer

- The trust monitored its performance through the NHS Safety Thermometer. This survey tool measured progress in providing a care environment free of harm for patients. The data was displayed in the ward areas for patients and staff to see, but it only included the previous month's performance and no trend data was displayed.
- We looked at the trust safety thermometer. The trust were aware that the safety thermometer had shown a high number of pressure ulcers and falls recorded in medicine. Effective action had been taken to reduce patient harm and the overall trajectory showed an overall positive trend in a marked reduction.
- The trust aimed to reduce all patient falls and falls causing harm in 2014/15. To support this, 'Fall Safe' risk assessments had been introduced to all wards, a link worker programme had been developed for supporting the prevention of falls and an updated information leaflet for staff and patients had been distributed.
- Additionally, progress had been made with support offered from the newly appointed falls prevention practitioner and dementia project lead nurse. Examples of this were the effective use of hi-lo beds and other relevant equipment, an increased awareness of falls prevention methods and additional education and support for wards with patients at high risk of falls.
- All grade two pressure ulcers were reviewed to prevent potential progression to grade three. The tissue viability team had been expanded to improve education and training. The pressure ulcer prevention plan had been amended to improve the recognition and classification of pressure ulcers. The quality and specification of all static and specialist mattresses and equipment that could contribute to pressure ulcers had been reviewed. An example of this was a new oxygen mask introduced to reduce the risk of pressure ulcers found on ears and noses. We observed patients being assessed for equipment that would relieve pressure.
- We were told that over the past 12–18 months significant effort had been made to ensure FRASE assessments were accurately completed in a timely manner and that relevant actions were considered and implemented.
- We reviewed the records of patients who had fallen whilst on the wards. We noted that of the two Patients were risk assessed using the Fall Risk Assessment Score for the Elderly (FRASE). We heard of significant effort being made by the staff to ensure FRASE assessments were completed in a timely manner. We were told that the accuracy of FRASE assessments had improved
- The CQUIN relating to reduction of venous thromboembolism (VTE) was met. The proportion of adult inpatients who have a VTE risk assessment on admission to hospital was appropriate and the completed root cause analysis confirmed cases of pulmonary embolism deep vein thrombosis.
- The target to reduce avoidable death, disability and chronic ill health from VTE was met, with 90% of admitted patients having a VTE assessment every month.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- 'Bare below the elbow' signs and hand gel dispensers were seen at the entrance to wards. Hand-washing facilities and hand gel was sited through the ward areas.
- We saw staff adhere to the trust policies for hand hygiene, personal protection equipment (PPE) and isolation.
- Weekly hand hygiene audits were undertaken, and the trust wide were results displayed on the quality board. These ranged from 25% to 100% compliance. Where results were low, the ward manager completed further spot checks and observations of staff.
- In several areas we observed poor infection control techniques relating to cannula care. Policy and procedures were not being followed, and this was brought to the ward manager's attention. The ward manager spoke with the member of staff, and assurance was given that all staff would be reminded about following the trusts policy and procedure.
- We identified wards with poor, cluttered storage facilities, dust covered shelves, and doors which were wedged open with a rubbish bin, all of which do not reflect good practice in infection control.
- The cleanliness of toilet facilities on Ward 9 was noted to be below standard. This was brought to the attention of the ward manager, who gave assurance that action would be taken to improve the hygiene standards.
- The trust's infection control team worked with wards and medical teams to support compliance with sampling, cleanliness and prescribing of anti-microbial medicines.
- There had been one cases of C. difficile and no MRSA reported at the Princess Royal Hospital between April and September 2014.

Environment and equipment

- We saw that patient areas were free from trip hazards to ensure their safety. Wards appeared tidy and organised.
- Equipment was replaced on a prioritised basis through the risk register.
- We saw resuscitation equipment in all ward areas, which had been checked as per the trust policy and procedure.
- In May 2014, at the CQC and Health Assure update, it was acknowledged that the current asset base of equipment, and particularly medical equipment, contained many assets that were beyond the expected life as recommended by the manufacturer.

Medicines

- We observed medicine cupboards and trolleys locked and stored safely. Medication administration record charts (MAR) were completed correctly. We saw allergy sections completed.
- Each ward had a dedicated pharmacist and a pharmacy technician.
- Pharmacy input was available on-site Monday to Friday, from 9am to 5pm, with an effective on-call service, out of hours.
- We identified a patient with an insulin pump; the pump rate was not documented, which could have led to the patient having the incorrect amount of insulin. This was highlighted to the ward sister, who reviewed the patient and took action to address the issue.
- A dedicated antibiotic pharmacist within the team ensured better monitoring and compliance with hospital antibiotic guidelines, based on good practice and local assessment of microbiology in the hospital and community.
- Prescribing issues were discussed with clinical teams, and also with consultant microbiologists, to ensure patients were receiving the most appropriate therapy.
- The CQUIN in 2013/14 for medicines management identified an improvement of the information, in discharge summaries and antibiotic prescribing checked as clinically appropriate in line with microbiology formulary, was partially met.

Records

- Medical notes were stored in open trolleys, unsecure on the wards, and we saw that some medical notes had been left in envelopes on a table in the Ward 9 corridor. This meant that notes were not being kept confidentially.
- We found nursing care plans were stored securely in document files.

Safeguarding

- Nineteen referrals had been made for medicine at the Princess Royal Hospital; all of the referrals were now closed. Staff were fully aware of how to refer a safeguarding issue, and had received training.
- The staff told us that the safeguarding lead nurse for the trust advised them whilst reporting incidents, and was very supportive. They supported nurses when attending adult safeguarding meetings.
- The new adult safeguarding policy and procedure was introduced throughout Shropshire, Telford and Wrekin

in April 2013. All agencies within the local adult safeguarding board, including the Royal Shrewsbury and the Princess Royal Hospitals, have adopted the West Midlands multi-agency policy.

Mandatory training

- Data showed that staff attendance at mandatory training was poor. Due to shortages of permanent staff, staff had not been released to attend mandatory training. Attendance levels for mandatory training were noted to be exceptionally low in some areas in medicine, percentage attendance rates ranged from 80% to 5%. The trust acknowledged this and told us it was looking at ways to improve attendance through ward-based learning.
- We were told of instances when staff had attended training, but the trainer had not turned up, or that the training was cancelled due to low staff attendance.

Management of deteriorating patients

- VitalPAC, a handheld device, was used to record and monitor patient observations. This system highlighted abnormal readings, and raised alerts for the staff to identify and support a deteriorating patient.
- The VitalPAC system used the data input to calculate an early warning score (EWS); a measure of risk for each patient. The system used these scores to alert the staff to patients who may be deteriorating, as well as recording when the next set of observations should be taken, according to the patient's individual level of risk.
- Staff told us of occasions when patient safety was being compromised during busy times. On a weekly basis, capacity issues within AMU had led to patients being cared for on trolleys. Staff had raised incident forms regarding this, as they felt that the trust did not recognise the seriousness of the situation.
- Care pathways were in place to ensure patients' needs were met. We saw that care plans had been updated.
- Comfort rounds were completed on each ward to ensure that patients comfort and safety were recorded between one and four hourly. These were audited by the ward manager.
- We saw that pressure ulcer prevention and falls risk assessments were completed where risks had been identified.
- We identified one confused patient in a side room without any observation, and this was highlighted to the nurse. We observed no stimuli being offered to this patient, which put the patient at risk of falls and further confusion.

Nursing staffing

- In March 2014, the Safer Nursing Care Tool (SNCT) was used at the trust to review patient acuity, dependency and staffing in all inpatient areas. As a result of this review, changes to the nursing establishment in adult inpatient wards were recommended and actioned in some areas. Medical ward staffing had increased, but the majority of the time, the extra staff had been agency or bank staff.
- The ward managers were supervisory 75% of their time. The ward sister led a team of staff on a daily basis to ensure patients' needs were met. Currently, on some wards, 50% of the staff were agency or bank staff, and this was putting a lot of strain on the substantive staff group, who felt that at times, patient observation was not sufficient, and care was not always given in a timely way.
- Agency and bank staff completed a full induction, and in some areas had been block booked to enhance a consistent team of ward-based staff. Some trained agency staff had completed the trust competency skills assessment, allowing them to complete high level tasks, such as giving intravenous drugs.
- Wards displayed a staff information poster, which showed the daily planned and actual number of staff (registered nurses and care staff) on each shift. These postersdisplayed who was in charge of each shift, and when the data was updated.
- End of the bed and 'bay entrance' handovers were carried out, depending on the sensitivity of the information. We saw that nursing staff used a printed patient handover sheet that was updated prior to each shift.

Medical staffing

- It had been acknowledged by the trust that they had insufficient consultant capacity (including vacant funded posts) in acute medicine. There were currently three vacancies; this was listed on the risk register, as several attempts to recruit had been unsuccessful. The

trust supported an acute unselected take; this means that a minimum of eight acute physicians were required to accept any patient coming in to the emergency department.

- The trust told us that they were continuing with all attempts to find sustainable solutions for appropriate cover in emergency medicine. Locum doctors were on the rota to support the team.
- An insufficient junior medical workforce had been identified to be able to deliver sufficiently safe and effective services across two sites. In particular, the AMU's did not have their own junior workforce, leading to cover doctors being pulled from medical wards, which disrupted ward-based services. Workload and stress levels had resulted in high sickness for junior medical staff; the highest proportion of sickness absence was associated with on-call and night working.
- The monitoring of recruitment and associated patient risk due to current staffing levels was undertaken via clinical quality review meetings (CQRM). Acute and emergency medicine continued to be amongst the greatest areas of risk. The trust reported that it was continuing work with other organisations and relevant professional bodies to identify sustainable solutions going forward. On-call, out-of-hours (OOH) responsibility for the medical team included surgical cover; there was not an OOH surgeon on-site. OOH cover for weekends and night-time was the responsibility of the FY1 (a grade of medical practitioner undertaking the Foundation Programme) and the CT2 (a senior house officer).
- Medical handovers varied from ward to ward, taking place formally and informally throughout the day. Consultant ward rounds took place on all wards, five days a week.

Major incident awareness and training

- Staff told us that should a major incident occur, the trust hada contingency plan. They had received basic training on this at induction. The trust worked together with other partners in a local resilience forum, as most major incidents would have an impact beyond the trust. They were part of theWest Mercia Local Resilience Forum (LRF), which helped them to work with other partners across Herefordshire, Shropshire, Telford & Wrekin, and Worcestershire,to plan for and respond to major incidents.
- Winter pressure arrangements were in place; however, a continual annual pressure was apparent. Delayed transfer of some patients into the community had reduced bed capacity.

Are medical care services effective?

Requires improvement

Medical care services required improvement to be effective.

Evidence from national audits showed that outcomes for patients could be improved. The trust scored low in the Sentinel Stroke National Audit Programme. There were poor results in rehabilitation goals, speech and language therapy availability and absence of continence plan were some areas which initiated the low score. The trust did not score well in national audits relating to coronary heart disease and management of diabetes.

The lack of a seven-day therapy service was impacting on patient recovery and delaying discharge. Some ward areas and equipment were out dated; faults were regularly reported, and some were placed on the risk register.

Staff competencies and appraisal rates ranged between 47% and 100%. Plans were in place to complete all appraisals by the end of the year. Lack of training meant that some staff had not been updated on current good practice issues.

Multidisciplinary team (MDT) meetings were effective, well managed and consistently carried out in all ward areas

Evidence-based care and treatment

- We saw that policies based on NICE and Royal College guidelines were available for the staff and accessible on the intranet.
- Evidence based care was promoted for the prevention of venous thrombo-embolism (VTE). For example, the use of prophylaxis anticoagulants.
- Care pathways were implemented in accordance with NICE guidance, such as the stroke pathway.
- Specialist treatment and care was provided for people who have experienced stroke or transient ischaemic attack, including facilities for rehabilitation.

- The promotion of the FRASE assessment by the falls prevention practitioner and dementia project lead nurse had shown a reduction of in-patient falls. Improvements in patient safety resulted in 15% reduction in falls.
- Patients were assessed on admission and risk assessments were put in place to reduce the risk of harm such as falls and pressure ulcer development.

Nutrition and hydration

- Patients told us that the food was generally edible and presented well. We saw patients using hand wipes before meals; we were told that they were not always given out.
- Dieticians supported and advised ward staff on patient care for diseases such as diabetes.
- Clinicians took advice from dieticians in developing diagnoses of nutritional problems. They provided individualised dietetic intervention using their expertise in food, nutrition, drug interactions, enteral feeding and counselling skills.
- The red tray system was used to alert staff to support patients requiring assistance with their diet.
- Nutritional risk assessments were in place for some patients. We saw food charts completed, which patients confirmed were accurately recorded.
- We saw fluid balance charts in place. We saw that the 'offered' and 'actual' fluid intakes were recorded accurately, reflecting a patients exact fluid intake.
- We saw that dieticians observed the VitalPAC scores, and monitored patient well-being. On one occasion we saw that staff had not alerted the dietician to high blood glucose levels. The dietician took the appropriate action to care for the patient.

Patient outcomes

- During 2012/13, 433 myocardial infarction patients (reported as STEMI, or ST segment elevation myocardial infarction) were seen by a cardiologist or a member of the team, and admitted to the cardiac ward, of which 399 were referred for or had angiography. This meant that appropriate action was being taken in a timely way.
- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP), which aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards, and national and local benchmarks. SSNAP is pioneering a new model of healthcare quality improvement, through near-real time data collection, analysis and reporting on the quality and outcomes of stroke care. The trust was assessed as Level E in September 2014. Poor results in rehabilitation goals, speech and language therapy availability, and absence of continence plans, were some of the areas which initiated the low score. An improvement plan for 2014/15 was in place.
- The trust submitted data to the Myocardial Ischaemia National Audit Project (MINAP), which was established in 1999, in response to the national service framework (NSF) for coronary heart disease. It examined the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales. The Myocardial Ischaemia National Audit Project (MINAP) 2012/13 showed the trust to be below the England average for three measures at both hospital sites.
- The trust submitted data to the National Diabetes Inpatient Audit (NaDIA); this audits diabetic inpatient care in England and Wales. In the 2013 survey, overall satisfaction scored 69.6%, meal choice scored 63.6%, and staff knowledge scored 82.5%.
- 11 of 21 NaDIA measures were better than the England average, and 10 measures were worse than average, including medication and management errors, poor staff knowledge, and delayed foot risk assessments.
- Standardised relative risk of readmission was worse than the England average for gastroenterology. Clinicians felt that the only possible recurring reason for readmission to gastrology related to patients requiring paracentesis, which would be a planned admission. Further work to understand the issues was planned.

Competent staff

- Staff told us that they had received informal supervision in the form of team meetings and occasional one-to-one discussions with the ward manager. Staff told us that the senior staff were supportive and available to discuss any concerns. They felt listened to and valued.
- Dementia care awareness training had been introduced, but this had not been embedded within the ward areas.
- Staff told us that they had attended training to improve their communication skills, and we saw evidence of good communication between staff and patients.
- Some staff held specialist qualifications. Nine of the fourteen trained staff on AMU had achieved an accredited critical care diploma/degree, and two were commencing the pathway.
- Staff told us that they were actively encouraged to undertake specialist courses, but staffing levels had limited the access to these.

- A revalidation management system was implemented as a requirement for all appraisals of medics in the trust in 2013. This raises a person's awareness to their behaviour and attitudes. The system provided one location for the storage of appraisal information, enabling the medical director / responsible officer more effective management of appraisals and portfolios, and promotes 360 degree feedback from colleagues and patients.
- To improve assurances, the NHS recruitment website for doctors had now been developed to include questions on revalidation and appraisal.
- Appraisals for the ward staff ranged from 47% to 100%. Therapy services staff appraisals ranged from 50% to 66%. Staff appraisals had been delayed due to staff shortages, and by the lack of time to meet with staff formally.
- Staff appraisals had been completed to ensure that staff were competent. Some managers had received 360 degree appraisals, which allowed them to reflect on their own practice and respond positively.

Multidisciplinary working

- Local collaborative working had led to the development of a heart failure service for the people of Shropshire.
- The Shropshire Heart Failure service was underpinned by multi-professional working across the primary/ secondary care interface. There were three heart failure specialist nurses located at the hospital. The aim of the new service was to improve outcomes in chronic heart failure, by impacting on quality of life, reducing hospital length of stay and hospital re-admissions, and when necessary, improving the end of life experience for patients and carers. The service provided access to appropriate investigations to confirm or refute the diagnosis of heart failure, an advisory role to health care professionals, patients/carer education, and an advice line.
- Multidisciplinary team (MDT) working was effective, and resulted in good outcomes for patients. We saw examples of rehabilitation services working together to support the safe discharge of patients and support for carers. We also saw how external MDT working was displayed, with cross-site discussions taking place to ensure that the patients were receiving the optimum care from the trust.
- The inpatient diabetes specialist nursing (DSN) team focused on patient support and education. They supported staff by sharing their knowledge and improving care standards. The DSN liaised with other health care professionals when required. The nurses regularly visited ward areas and departments to provide specialist advice for both staff and patients. They were responsible for supporting ward staff and departments in delivering a high standard of diabetes care, and provided teaching sessions. They also supported the outpatient clinics for diabetes reviews, type 1 diabetes in pregnancy, and joint renal and diabetes clinics.
- Patient handover from department to ward was by telephone and handover sheet; plans had been discussed to make this a nurse-to-nurse handover; the staff welcomed the introduction of this change to procedure.

Seven-day services

- We were told that to improve patient outcome, the consolidation of stroke services will continue during 2014/15, aiming for a seven-day service to be in place.
- Currently seven day ward rounds were not being carried out
- Occupational therapy or physiotherapy services were not available at weekends or Bank Holidays. Due to rehabilitation services being absent during weekends, the physiotherapists and occupational therapists had trialled Saturday working on a voluntary basis, to ascertain its value. Supporting patients recovery had been a huge success in promoting earlier, safe discharge, but this had not been promoted by the trust.
- At present, the trust is unable to provide a full seven-day stroke service; recruitment to a fourth consultant post had been identified, with the plan being to expand the team by the end of 2014.
- To support patient's safe care, consultant presence out of hours (OOH) was via the on-call rota. Haematology on-call was based on-site. Weekend OOH imaging and pharmacy was available through an on-call system. The outreach team were available within the wards for support of a deteriorating patient, and the 'hospital at night team' was also available. Pharmacists were in the hospital on Saturday mornings to dispense and support weekend discharges.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that they were aware of their responsibilities around the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). They were able to demonstrate a good understanding of the processes.
- The mental health team attended the wards on request, to support patients to make decisions if needed.
- We observed patients being asked for verbal consent prior to procedures being carried out.

Are medical care services caring?

Good

Patients and relatives that we spoke with were all satisfied with the care they received; we heard no negative feedback. Friends and Family Test (FFT) response results varied. Some wards had a greater response than others, and the ward managers were using their initiative to ensure that all staff asked patients for their feedback. Patients and relatives told us that staff were kind and caring. Patients were informed about their care, and knew what was happening to them.

Compassionate care

- Friends and Family Test data showed that the medical wards scored positively for the most recent results for July 2014
- CQC inpatient survey results scored average for all areas, but below average inpatient views being sought and the availability of information on how to make a complaint.
- Clinical commissioning group cancer patient satisfaction results showed that although local patients seemed broadly satisfied, they did not feel that they had been offered written assessments or care plans, scoring just 15%. Nationally, scores ranged from 7% to 35%.
- We observed compassionate care and attention being delivered. Patients told us that they had been well cared for.
- We observed staff protecting patient's privacy and dignity, shutting curtains around the bed area securely, and lowering their voices to discuss personal information.
- Staff were observed to be kind and caring when supporting people's mobility, and offering support during meal times.
- We saw staff introduce themselves to patients and relatives.

Patient understanding and involvement

- All of the patients we spoke with told us that they were aware of what was happening to them; they told us that they felt involved with their care.
- Patients told us that they felt safe, and their fears were alleviated by the nursing and medical staff.
- People told us that they felt informed about their relatives care, and that all the staff had been supportive. They told us that staff were very kind and caring.

Emotional support

- Clinical nurse specialists offered emotional support and advice for patients and staff.
- Chaplains worked as a team of whole-time and part-time chaplains, with the support of volunteers 24-hours a day, seven days a week. They represented different denominations, and had contact with all the major faith communities.
- The experienced bereavement care team at the trust provided a caring and compassionate service, offering support and reassurance, information and guidance.
- The trust offered a range of options for emotional and psychologicalhelp, in their programme of supportive and psychological therapies.
- We observed registered nurses, healthcare workers, therapists and student nurses assisting patients, demonstrating respect and kindness, and maintaining patient dignity at all times.
- We observed reassurance and advice being given to patients, and we saw that patients had their call bell within reach.
- Patients told us that they thought the call bells were responded to within good time scales, and they had not had to wait an unreasonable amount of time for attention.

Are medical care services responsive?

Requires improvement

We judged that medical services required improvement to be responsive.

Medical care (including older people's care)

The flow of patients through the hospital was disrupted due to high numbers of medical patients being admitted and delays in discharge arrangements being made. This led to medical patients being cared for on non-medical wards and increasing the dependency for nursing care on those wards.

The trust planned to introduce a more person centred approach to care and services for patients living with dementia that included an integrated patient pathway using best practice working across primary, community and secondary care. They had trained dementia champions in some areas and improved signage and labelling on key wards. This process had been delayed due to staff shortages.

Patient complaints were listened to and responded to. PALs leaflet and how to complain information was displayed throughout the hospital.

Service planning and delivery to meet the needs of local people

- The Commissioning for Quality and Innovation (CQUIN) payment framework sets targets to be met. Targets for dementia care had been met, including ensuring that at least 90% of patients aged over 75, and who are admitted, were assessed and referred on to the relevant specialist services. The trust ensured that there was sufficient clinical leadership and appropriate training undertaken to adequately support carers of people with dementia.
- The trust had developed guidelines following investigations and reports, such as Healthcare for All (2008), and Six Lives (2009). These had highlighted the additional need for 'reasonable adjustment' to service delivery when patients with a learning disability were admitted to a general hospital. The objective that the patient will be nursed in a safe environment, was supported by a reference guide to assist in the planning of care for patients with a learning disability who were admitted to or who attend the trust.

Access and flow

- From data supplied by the trust, there were 1,055 medical outliers from May 2013 to April 2014. The cardiology speciality accounted for 30% of these.
- During 2013/14 the trust focused on improvements to support patients when ready for discharge. A new discharge procedure and a discharge information leaflet for patients were introduced. Patient choice' letters were issued to all patients, to explain the admission to discharge process.
- A discharge hub was established that provided a centralised control centre to aid communication between the trust and its external partners. This has since been closed, and patients are now discharged from the wards. Discharge co-ordinators supported the wards and attended bed capacity meetings.
- Staff and patients told us that discharge arrangements were discussed at the earliest opportunity, to ensure that patients were discharged home safely, and adaptations to the home environment could be arranged if necessary.
- Some delays in discharge were noted by staff due to social care issues, and difficulties in arranging care and support in the patient's own home. Lack of support for stroke patients at weekends also impacted on a delayed discharge, due to no therapy services being available.
- To improve patients discharge, a new discharge procedure was introduced, including a patient discharge information leaflet and a 'patient choice' letter that clearly explains the process from admission to discharge. The trust recruited to a new role with responsibility for site safety, capacity and improving discharge planning.
- Referral to treatment (RTT) was above standard and in line with the national average. RTT was meeting all of the five required standards. RTT for general medicine was 100%. The trust has developed a RTT patient information leaflet explaining the 18 week patient availability.
- For the period January to March 2014, the cancer patient experience survey showed no identified risk for three measures; a 62 day wait for first treatment from urgent GP referral, a 62 day wait for first treatment from NHS cancer screening referral, and a 31 day wait from diagnosis.

Meeting people's individual needs

- Single-sex accommodation was provided on all the medical wards.
- The trust had developed guidelines following investigations and reports, such as Healthcare for All (2008) and Six Lives (2009). These had highlighted the additional need for 'reasonable adjustment' to service delivery when patients with a learning disability were

admitted to a general hospital. The objective that the patient will be nursed in a safe environment was supported by a reference guide to assist in the planning of care for patients with a learning disability who were admitted to or who attended the trust.
- A learning disabilities nurse specialist supported patients with a learning disability diagnosis.
- The trust was addressing the quality of care provided to patients living with dementia in some areas. They planned to introduce a more person-centred that included an integrated patient pathway using best practice working across primary, community and secondary care. Dementia champions had been trained in some areas and improved signage and labelling on key wards was seen. This process had been delayed because of staff shortages.
- The trust had listened to carers groups and implemented a carer's passport scheme that enabled a designated carer or family member carer to support a patient's stay in hospital outside of normal visiting hours. The main beneficiaries of the scheme were people caring for patients living with dementia; planned to and people who have a significant caring role for the patient in the community. The scheme encouraged staff to value and support each person's carers and to include them as active members of the care team and to support their visits during the day. We saw evidence of this on the wards.
- The Butterfly Scheme had been introduced to support patients living with dementia. However, there was no equipment available such as adapted cutlery, crockery or environment enhancements to support the scheme on the stroke unit or wards.
- A revised tool had been introduced for the identification and screening of patients with dementia. A dementia care bundle had been made available and was fully embedded in the elderly care ward.
- The trust had implemented a scheme to identify carers for those patients with dementia and signpost them to help and support. They have worked with the patient and carers hospital liaison worker to support families and carers. The inclusion of carers and relatives had improved this in the stroke unit.
- Staff told us they worked in an environment in which employees, patients and visitors are treated with consideration, dignity and respect, free from harassment and intimidation.
- The trust arranged when necessary for an interpreter or translator to assist patient consultation either face to face or by telephone. Interpretation services were available in both the form of a language line (a telephone translation service) and face-to-face interpreters.
- We saw a many advice/information leaflets were available for patients and relatives to read about self-help, medical conditions and access to services.

Learning from complaints and concerns

- The annual complaints and Patient Advice and Liaison Service report for 2013/14 noted that 70 complaints had been received for acute medicine.
- Medical concerns were primarily relating to diagnosis, treatment and complications that occurred as a result of treatment. Of those complaints relating to staff attitude, 37 related to nursing personnel and 28 to medical staff. During the year, the trust launched its values, setting out the behaviours expected of every member of staff. Further work was on-going to embed these values throughout the organisation.
- The complaints team usually met with heads of nursing and matrons each month to highlight themes and further action required. During the last quarter, the complaints team had met with the clinical governance lead and senior managers from each specialty every two weeks, to highlight new complaints, and agree actions and learning. Each specialty was now seeing a reduction in the number of complaints it had received.
- The matron for medicine reviewed each complaint, and the issues were discussed within ward meetings.
- We saw 'Don't take your troubles home with you' stickers on lockers, to support patients to raise concerns prior to being discharged.
- The Patient Advice and Liaison Service (PALS) was available to give support and advice, and we saw leaflets on the wards to support patients to make complaints and raise concerns. Patients we spoke with were aware of how to make a complaint.

Are medical care services well-led?

Good

We spoke with staff who were aware of the trust vision and values. Staff told us about the new open culture. They felt

that they were well managed at ward level, but there was some disconnect between them and the senior executive team. It was acknowledged that staff shortages had impeded some initiatives. For example, the dementia care initiative and delayed discharges into the community had resulted in poorer outcomes for some patients. Medical staff shortfall had also caused stress and anxiety for the workforce. Ward level leadership was found to be effective and well managed. Staff had received recognition and rewards from the trust.

Vision and strategy for this service

- The executive team and staff told us that the trust vision was to ensure that the interests of the patients were at the heart of everything they do, providing the best possible care to them.
- The trust values represented a commitment that the decisions they make will be in the best interests of the people they serve and the people they employ.
- Staff were familiar with the trust values, which were 'proud to care, make it happen, we value respect and together we achieve'. These values were now incorporated within the induction and appraisal process, and staff told us that they welcomed them.

Governance, risk management and quality measurement

- Monthly ward to board quality reviews were completed and monitored. These included monitoring comfort round checks, speaking with the patients, ward cleanliness, and patient knowledge and understanding of their medication.
- Nurses described difficulty in accessing the local governance meetings with medical colleagues due to staff shortages, which could compromise multidisciplinary learning from incidents and complaints.
- There were several items on the medical risk register, including a lack of piped oxygen and suction in the renal unit, along with water supply issues, the need to replace the outdated renal dialysis station, and a shortfall in the medical workforce, including insufficient consultant capacity in acute medicine. Substandard cardio-respiratory accommodation and absent junior workforce in AMU had been identified as being destabilising for the ward-based services. Workload and stress levels had resulted in high sickness for junior doctors, and the highest proportion of sickness absence was associated with on-call and night working. Significant trained nurse vacancies on medical wards were acknowledged. The current vacancy gap for trained nurses resulted in shifts not being covered, impacting on the quality of nursing care, and on the morale and resilience of substantive staff.

Leadership of service

- Ward level leadership was found to be robust and effective.
- Rewards and recognition were in place, and staff told us how they had achieved the Chairman's Award. 'Chocolate box moments' were awarded to ward staff with zero pressure ulcers reported.
- On many occasions, nurses told us that they felt able to raise concerns with senior management and were listened to.
- Staff told us that their director of nursing was approachable and very supportive.

Culture within the service

- A new open culture was described by staff; team work was improving and they felt able to speak with the executive team when they visited the wards.
- All the staff we spoke with felt supported by the matrons and ward manager/sisters.
- Although some disconnect was described between ward staff and executives, there was evidence of high visibility of the director of nursing amongst ward managers spoken to, and they valued their support.

Public and staff engagement

- The trust had introduced a quarterly newsletter for public members of the trust, 'A Healthier Future'.The newsletter was sent to all trust members by post or email notification, and could also be downloaded from their website.
- The role of the volunteer was a vital feature within the hospital, working in a variety of departments alongside staff. Currently over 400 trust volunteers worked across both hospital sites, involved in a wide range of areas, including chaplaincy, with dementia activities, and as ward helpers and mealtime buddies.
- Patient representatives were visible throughout the hospital.
- Staff were being encouraged to promote the Friends and Family Test (FFT).
- The trust newsletter updated staff on current issues. Ward meetings were held to discuss local issues with their own staff.

Medical care (including older people's care)

- An intranet site was available for all staff, which held the trust policies and procedures.

Innovation, improvement and sustainability

- The trust planned to focus over the next 12 months on ensuring improvements in dementia care, reducing harm to patients, and in improving the experience of patients, relatives and carers.
- The trust was awarded third prize for Innovation in Dementia Care by the Royal College of Nursing (RCN) in May 2014. The award was presented to the trust during Dementia Awareness Week and also in the week that the trust introduced the national 'Butterfly Scheme', which allowed people with memory impairment to receive a specific form of personalised care during their stay in hospital.

Surgery

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

Information about the service

The Princess Royal Hospital, Telford provides inpatient and day surgery services for specialisms including trauma and elective orthopaedic surgery, head and neck (ENT), and day surgery, amongst others. The hospital had 10,757 admissions in 2013/14, with more than half being day surgery admissions. The hospital has consistently struggled to meet the 18 week referral to treatment time (RTT).

We inspected theatres (including the temporary Vanguard theatre) and recovery, three wards and the day surgery unit. We spoke with staff, patients and relatives, and we observed care, and reviewed records as part of this inspection.

Summary of findings

Services were not always safe, as there were delays in getting equipment; intravenous fluids and medicines were not stored correctly; there was insufficient surgical cover after 5pm; and no acuity tool was used to determine safe staffing levels in real time, although the Safer Nursing Care Tool was completed quarterly to determine planned staffing levels. Audit data demonstrated that some patient outcomes were not as good as the England average, and there was a lack of competency assessments for staff. There were no formal arrangements for physiotherapy cover for the trauma ward, which was operated on a volunteer basis.

Services were caring; we saw positive staff interactions with patients, and staff demonstrated genuine empathy and rapport with patients. Surgery was not always responsive, as it failed to meet treatment times for some specialities. Patients, including children, could be kept waiting in day surgery before being found a bed, and moves between wards also occurred. Services were not well-led, due to a lack of vision for the service in some areas, as well as change of leadership and reorganisation. Staff wanted to ask questions of board level managers, and felt they had been stopped from doing so.

Surgery

Are surgery services safe?

Requires improvement

Surgical services were not always safe. We found rooms and cupboards containing intravenous fluids, including an antibiotic, to be open and easily accessible, and there were delays in providing equipment. Staff told us that they did not always receive feedback about incidents or lessons learnt, and that on occasions, they were too busy to report incidents. There was no acuity tool in use, although staff were often caring for patients from other specialties, and we found that the only surgical opinion after 5pm was via an on-call system, even though surgical patients may present to the emergency department. We saw that patient risk was identified and properly escalated, and that mandatory training rates were improving.

Incidents

- There had been 32 serious incidents reported by the trust across the trust surgical divisions in the preceding 12 months before the inspection. Pressure ulcers were the most frequently reported serious incident.
- Staff were aware of what constitutes an incident, but felt that they did not always receive feedback or lessons learnt from incidents.
- We spoke with staff who told us that they were aware of the electronic incident reporting system, Datix. A number of staff we spoke with told us that they did not have the time to report incidents via the electronic incident reporting system. During our inspection we were made aware of an incident that should have been reported, but staff told us that it had not been. One staff said "Datix is time consuming, we don't do it for all. We don't get answers from them so what is the point?"
- In theatres we saw that there was prompt identification of serious incidents, and that they were investigated and lessons learnt.
- Governance meetings, including mortality and morbidity meetings, were undertaken within the directorate.

Safety thermometer

- The Safety Thermometer was in use by the surgical directorate.
- We saw that the data indicated good compliance with hand hygiene, VTE assessments and pressure area care and assessment.
- The Safety Thermometer was visible on entry to the wards, so that patients and other members of the public could see the performance of the ward.

Cleanliness, infection control and hygiene

- Data reviewed prior to the inspection showed that MRSA rates were below the England average for the trust. C. difficile infections were lower than the England average for the majority of the period.
- The surgical directorate took part in the national surgical site surveillance for orthopaedics run by Public Health England. The last available data for 2012/13 showed that infections were below the England average.
- Theatres and ward areas were clean and fit for purpose.
- We saw that hand hygiene audits were completed regularly, with positive results.
- There was sufficient personal protective equipment available, and we saw staff using the equipment appropriately.
- Staff worked in accordance with trust policy, were 'bare below the elbows' and maintained correct hand hygiene. We saw high dusting being completed as part of the usual cleaning round.

Environment and equipment

- Staff told us that in the main, they had the necessary equipment to carry out their duties. However, we were aware of an incident that meant that they did not always have sufficient equipment to safely carry out their work.
- Day surgery staff told us that they had waited almost a year for an electrocardiogram (ECG) machine, despite there being an acknowledged need for one from the trust. The day surgery unit commonly cared for inpatients in line with the hospitals escalation policy. We saw that an ECG machine had been provided by the League of Friends for the hospital.
- Emergency equipment on the wards was checked daily to ensure it was complete and ready for use.
- The wards and clinical area were well maintained. The head and neck ward had had a refurbishment, and offered four side rooms that all had en suite facilities.

- Equipment we saw in theatres was complete, fit for purpose, and appropriately maintained in line with manufacturers recommendations.

Medicines

- We found that medicines were not always stored securely on surgical wards, including on the head and neck ward, and orthopaedics.
- The 'clean utility' rooms behind the nurse's stations were used for storage of intravenous fluids and an antibiotic (metronidazole). These rooms were left unlocked, and on some occasions, the door was propped open. Inside the room, the fluids and antibiotic were kept in cupboards that were not locked. We were told that keypads had been ordered for the doors, but had not yet arrived. This meant that medicines were not stored correctly.
- Medicines that required refrigeration were kept in a locked fridge. Temperatures were checked daily, and we found them to be within acceptable limits.
- Staff told us that pharmacy personnel were able to supply medicines quickly, so that patients received the right medication at the right time.
- We were told that there could be some delay, on occasions, for medicines for patients to take home when discharged, but patients received their medication in a timely manner.

Records

- Records were a mixture of paper records and an electronic package called VitalPAC that recorded patient's observations, and indicated when assessments were required.
- Staff told us that it was not unusual for VitalPAC to malfunction, and that staff returned to paper records for observations. Staff told us that they did not always report the system malfunctions as an incident.
- We saw that there was some duplication of records, whereby observations and assessments completed electronically were then transcribed onto paper records.
- We saw that risk assessments for pressure areas were appropriately completed, and action taken in response to the assessment. We saw that pressure area assessments and falls assessments were completed regularly, and when a patient's condition changed.
- Medical staff wrote in a different set of notes to nurses and allied health professionals. A single set of notes allows staff to review the patient's condition in a chronological manner, ensuring that the reader has a clear picture of what is happening to the patient at any given time.
- We saw that the World Health Organisation (WHO) 5 step to safer surgery checklist was completed in theatres and that it appeared well embedded in practice. The checklist was regularly audited, with over 1,400 patients audited showing 100% compliance.

Safeguarding

- Staff had received safeguarding training for adults.
- Staff we spoke with were aware of how to raise a safeguarding concern within the hospital, and what constituted a safeguarding issue. They told us that they were well supported by the hospital safeguarding team.

Mandatory training

- Staff told us that they were up to date with mandatory training, and that it was completed as face-to-face and electronic learning.
- Training included basic life support, moving and handling, and infection control, amongst others.
- We saw that mandatory training rates had improved in the six months prior to our inspection, and that the vast majority of staff had completed their mandatory training. On two wards, we saw that mandatory training was completed by 85% of the staff.

Management of deteriorating patients

- The surgical wards used the 'early warning system' (EWS) to alert staff to patients who were becoming increasingly unwell. This score was calculated by VitalPAC from the observations recorded.
- Staff on the orthopaedic ward told us that they were not always supported by outreach staff from the critical care unit. They told us that as there was a junior doctor allocated to orthopaedics, the outreach staff regularly asked for the doctor to review the patient. We were concerned, as outreach staff have a different skill set to many junior doctors, and are experts at caring for unwell and deteriorating patients.
- We were told that medical staff responded promptly when requested by nursing staff to review patients.

Nursing staffing

- Data we reviewed prior to the inspection indicated that the trust had a higher use of agency and bank staff than the England average.

Surgery

- We reviewed rotas, and found that staffing was mostly maintained to the expected levels.
- The wards displayed the number of staff that should be rostered onto a shift, and the number actually working.
- Staff on all the wards we visited told us that they regularly cared for patients from specialties other than their own, such as medical outliers, and those who may require different levels of care. This was particularly true of the day surgery unit. We asked if an acuity tool was used to determine the needs of patients and the correct level of staffing, but we were told that no acuity tool was used to determine staffing levels.
- Staff told us that they were sometimes concerned about the skill mix when they were caring for people from other specialities, as they were concerned that those patients required different interventions than those they were used to caring for.
- A number of wards and theatres had a low turnover of staff, which ensured a level of continuity in the care provided.
- Senior staff told us that wherever possible, they used agency staff, who were used to working on the ward and at the hospital. This included the theatres, which had six long-term agency staff, as they had a number of vacancies.

Surgical staffing

- Data we reviewed prior to the inspection showed that whilst the trust had a higher than the England average of junior and middle career grade doctors, it had less than the England average number of senior doctors (registrar and consultant groups).
- We were made aware that general surgical cover after 5pm was provided on an on-call basis. This meant that the surgical registrar had to be contacted by the on-call physician or the emergency department. Although there was no inpatient general surgery provided at the Princess Royal Hospital, the emergency department still treated surgical patients who attended the department.

Major incident awareness and training

- We saw that there was a major incident plan in place for the trust, and for the surgical service.
- There were business continuity plans in place for surgical services, which outlined the response to a significant problem, and the prioritisation of patients and care.

Are surgery services effective?

Requires improvement

There were some care pathways in place, but not all were up to date. Audit data showed that some patient outcomes were not as good as the England average, although we were aware that action was being taken to address this. We were concerned that there were limited competency frameworks in place for nurses and, in particular, for tracheostomy care. There were no formal arrangements for physiotherapy cover for orthopaedics over a weekend; this service was run on a volunteer basis only.

Staff gave us inconsistent responses when we asked about the Mental Capacity Act, and told us that it was normally the doctor's responsibility to complete the assessments. We saw that patients received pain relief in a timely way, and in a method best suited to them, and that there was effective multidisciplinary working.

Evidence-based care and treatment

- There were a limited number of surgical pathways, and those that were used were not always the most current.
- There were no pathways currently in use for head and neck surgery.
- We saw that the fractured neck of femur pathway was dated to 2010. NICE guidance for fractured neck of femur was published in 2011, with a short update in 2014. This meant that we could not be sure that the pathway reflected current NICE guidance or best practice.
- There were orthopaedic pathways for elective knee and hip replacements. These were commenced in pre-operative assessment clinics, and carried on until discharge.
- We saw that staff adhered to local policies in relation to the management and observation of patient's pre-, peri- and post-surgery. These conformed to NICE guidance CG50 – Acutely ill patients in hospital.
- We saw that theatres had a comprehensive audit schedule of clinical practice, documentation and departmental cleanliness.

Pain relief

- Patients pain relief regime was considered initially at the pre-operative assessment clinic, which allowed staff to plan effective pain relief for patients.

- We saw that the type of procedure, operation duration, patient risk factors, and patient choice all influenced the pain relief plan.
- Post-operative pain was controlled by a variety of methods, including oral pain relief, as well as patient-controlled analgesia and epidural.
- Pain scores were regularly completed for patients in the post-operative phase of recovery. We saw a staff interaction where pain was thoroughly assessed.

Nutrition and hydration

- Patients who were unable to eat or drink received support by means of intravenous fluids.
- Patients who were assessed as being at risk of malnutrition were referred to the dietician.

Patient outcomes

- Data reviewed prior to the inspection showed that the hospital performed worse than the England average for six measures in the hip fracture audit, including time taken to surgery.
- The hospital was taking steps to improve this. We were aware that the trust had recently appointed an ortho-geriatrician, and that they were due to commence work in the near future. We requested the most up-to-date hip fracture audit data to demonstrate improvement, and found that on average, patients waited longer than 36 hours for their operation against an England average of 31 hours.
- Data reviewed showed that readmission rates for elective and emergency patients at the hospital were better than the England average.
- Data reviewed for Patient Reported Outcome Measures (PROMs) showed that the majority of patients reported improvement following surgical intervention, and this was in line with or better than the England average for hip and knee replacement.
- Patients length of stay following surgery was in line with the England average.

Competent staff

- All staff we spoke with told us that they had received appraisals in the last year. On the orthopaedic wards, appraisal completion was in excess of 90%. Data provided showed that 60% of day surgery staff had had appraisals. Consultants we spoke to as part of a focus group told us that they had received appraisals, which were required as part of their professional revalidation.
- Nursing staff told us that they undertook competency programmes for skills such as medicines management.
- Some wards had a mixture of specialisms due to bed capacity issues. We asked if there were competency frameworks in place, so that staff had the necessary skills to care for patients of differing needs, but we were told that there were no competency frameworks in place.
- We were further told that there was no competency framework in place for the safe management of tracheostomies, even though there was a dedicated head and neck ward. Staff reported that they had a significant number of patients through the ward who required this intervention. We asked how the trust knew that staff were competent to manage tracheostomies, and we were told that it was through supervised practice by experienced staff.
- Due to service reconfiguration, gynaecology services had been moved to the hospital. We saw that theatre staff had received additional training to prepare for this.

Multidisciplinary working

- We saw that the multidisciplinary team (MDT) worked effectively at ward and surgical division level. Staff reported a good working relationship with colleagues from other disciplines.
- Patients were routinely referred to members of the MDT for review and specialist input. We saw an example of a patient, who was assessed as being at risk of malnutrition, and a referral to a dietician was made.
- Cancer patients were routinely discussed at MDT meetings to determine the best course of treatment and care for them. This was true in the ear, nose and throat (ENT) ward.
- We were concerned to find that pharmacy support was not provided to inpatients on the day surgery unit. We were told that this was because they were not funded to cover the unit. Day surgery had medical inpatients who were judged clinically stable, but who may still require specialist review of medicines.

Seven-day services

- Out-of-hours services were available, including pharmacy and radiology.
- There were clear on-call arrangements for doctors overnight and at weekends, although we remained concerned about the lack of general surgical cover after 5pm.

- Orthopaedic trauma patients were reviewed daily on the ward.
- We were concerned to find in orthopaedics that there was no seven-day physiotherapy service, as they did not always cover weekends. This meant that patients who had surgery for a fractured hip on a Friday may not get specialist physiotherapy until the Monday. Staff told us that a physiotherapy service was only provided on a voluntary basis, and as such it may not always be available. Early mobilisation is an important indicator of patient outcome and to reduce the risk of complications.

Access to information

- We saw formal ward rounds being undertaken, and that medical, nursing and allied health professionals had the information they required, such as records and test results, which allowed them to effectively care for patients.
- The majority of staff we spoke to told us that access to information was not always possible when there were technical problems with VitalPAC (electronic records), and they used paper records as a back-up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the Mental Capacity Act (MCA) assessments were completed as part of the consent process. The assessments were kept in the medical notes.
- We saw consent being given formally for a procedure. Adequate time was taken and the patient was given the opportunity to ask questions. The risks and benefits of the procedure were clearly explained, allowing the patient to make an informed decision.
- We spoke with three nursing staff, who told us that the assessments were completed by the doctor and that the nurses were not usually involved in completing them. One staff told us "it is up to the doctor to do the MCA paperwork".
- We asked nursing staff about their knowledge of MCA and received inconsistent responses, so we could not be sure that staff were aware of their responsibilities under the MCA.

Are surgery services caring?

Good

Surgical services were caring, and staff showed compassion and empathy for the patients they were caring for. We saw positive staff interactions based on mutual respect. Friends and Family Test results for the hospital were positive for all wards. Patients told us that they received excellent emotional support from ward staff and clinical nurse specialists.

Compassionate care

- Data we reviewed prior to the inspection, and data we saw at the hospital, showed that the surgical wards at the hospital scored positively on the Friends and Family Test. For example, the head and neck ward for September 2014 had 51 patients extremely likely to recommend the ward and three likely, with no detractors.
- Patients told us that most nurses and staff were kind and compassionate.
- We saw a number of good staff interactions with patients. Staff used humour to build rapport with patients, and had a good understanding of individual patient's needs.
- Staff on the head and neck ward told us how they supported patients who required life changing surgery, and they demonstrated a clear passion and empathy for caring for these patients.
- In theatres we saw that the privacy of patients was protected, and that people were moved in a way to protect their dignity.
- We saw a patient being assisted with their meal. The nurse took time to assist the patient and helped them in an unhurried way. They made conversation and had a clear rapport with the patient.

Patient understanding and involvement

- We saw that patients were given adequate time and information with which to make decisions.
- Patients we spoke with told us that staff explained their care and treatment to them on most occasions before any care or intervention took place.
- Staff we spoke with told us that they were sometimes concerned about the continuity of care offered to patients, due to the use of agency and bank staff.

Surgery

Emotional support

- In the pre assessment unit, patients were met by a member of the nursing team and directed to the appropriate room for their appointment. Patients told us that this was reassuring and welcoming. We saw that patients were given adequate time to answer questions, and to ask if they were unsure about their forthcoming operation or procedure.
- Staff told us that there were counselling facilities available in the community, and that they had referred patients requiring further support to them.
- Clinical nurse specialists saw patients on the wards and in pre-operative assessment. They were able to offer advice and guidance to patients. Two patients we spoke with spoke highly of the breast care nurses, in the support and care they had received from them.

Are surgery services responsive?

Requires improvement

Latest referral to treatment time data (August 2014) showed that the hospital continued to struggle to meet some targets. The number of patients with a fractured hip who were operated on within 48 hours was below the England average. In the day surgery unit, patients, including children, were kept in a waiting area for some time if beds were not available. Capacity and flow problems also meant that some patients were moved between wards in the post-operative phase of their treatment.

We saw positive care for patients with dementia, and responsive care planning for patients undergoing elective hip and knee surgery. Patients spoke highly of the ease and convenience of the temporary Vanguard theatre.

Service planning and delivery to meet the needs of local people

- There was an effective pre-assessment department, which supported patients in preparation for their operation. There was good flexibility in pre-assessment to provide this service in a way or place that was convenient for patients, in that patients could attend a pre- op clinic in Shrewsbury or Telford, depending on what suited them best.
- The use of the temporary Vanguard theatre addressed a local need to increase the number of day patient services, such as arthroscopy.

Access and flow

- Information we reviewed prior to the inspection showed that bed occupancy in the last quarter with available data was at 90% across both hospital sites. This was higher than the England average.
- The number of patients who had surgery cancelled and were not re booked for surgery within 28 days was better than the England average.
- Data for referral to treatment times (RTT) was reviewed for August 2014. This showed that the trust was failing to meet the 90% treatment target for orthopaedics (66%). ENT was meeting the target at 92%, although it had been failing to meet the target prior to August.
- We were aware that the trust had reported that they had met all RTT for September 2014, but this data was not ratified at the time of our inspection.
- The number of patients with a fractured hip, who were operated on within 48 hours at the Princess Royal Hospital, was 75% according to the last available data, which was worse than the England average (83%).
- We were told that the absence of a dedicated hip fracture theatre list at the weekends had an impact on the time taken for patients with fractured hips to be operated on, as they may be given a lower clinical priority to other emergencies.
- The trauma anaesthetist also covered other areas, such as the emergency department, which could potentially lead to disrupted lists.
- The number of operations cancelled was in line with the England average.
- We spoke with staff, who told us that cancellations in day surgery were common due to the number of inpatients being cared for on the day surgery unit. The day surgery unit was commonly escalated into inpatient beds when the hospital was under pressure. Staff described how some patients were cancelled on the day of surgery on the week preceding our inspection.
- We were told that a bay on the elective orthopaedic ward was going to be used as a surgical assessment unit for patients with orthopaedic, head and neck, or breast surgery problems. This was at the planning stage, and we were told that a date for opening had not been agreed.

Meeting people's individual needs

- Translation services were available, and staff knew how to access these services.

- We were told that due to a large number of inpatients on day surgery, day surgery patients were required to sit in the waiting area. On an occasion in the week preceding our inspection this had included children, who were kept in the waiting area for several hours. We were told that room was found for them on the paediatric ward; two children then had their operations cancelled.
- Originally, the day surgery unit had only 14 chairs in the waiting area, though the area was used more frequently due to inpatient use of beds. An additional 28 seats were provided by the League of Friends for patients waiting in this area.
- Day surgery staff told us that increasingly, people requiring surgery, such as elective orthopaedic surgery, were admitted to the day surgery unit. On occasions, they returned to the unit post operatively until a ward bed could be found. This meant that patients were moved between wards shortly after surgery.
- Day surgery patients and inpatients on the day surgery shared bays. Whilst inpatients received a hot meal and drinks, day surgery patients had snacks. Staff told us that this sometimes led to antagonism.
- We saw, on one ward, that a patient was admitted with dementia. We saw that staff had ensured that he was treated first and not kept waiting, and they had also involved a local charity to give advice on how to manage the situation.
- Elective hip and knee pathways identified patients' needs preoperatively, so that individual care could be appropriately planned.
- The Vanguard theatre meant that patients could be admitted, receive treatment and recover in a single clinical area that was convenient.
- The orthopaedic wards had wet rooms, so that patients with reduced mobility were able to maintain independence.
- There were two showers rooms for 24 patients on the day surgery unit. Staff told us that there were queues for the wet rooms when they had inpatients.
- Information was available to patients in written form, such as leaflets and other information, which was sent to them pre operatively.

Learning from complaints and concerns

- We saw that clinical areas kept a log of the complaints received.
- Senior staff were aware of the number of complaints received, and any key themes that were identified.
- Staff we spoke with told us that they received feedback about complaints, and any changes to practice or procedure. Meeting minutes showed this to be the case.

Are surgery services well-led?

Requires improvement

Surgical services were not well led. Some staff were aware of the vision for their service, while others were not. Staff told us that they had seen the director of nursing in the clinical areas, but could not remember seeing other executives. We were told that staff had wanted to ask a question of senior staff, but this had been stopped and they were unable to do so. There was disengagement between staff and senior managers. Staff told us that frequent change of leaders and clinical reorganisation had led to instability in the service.

Vision and strategy for this service

- We spoke with a number of senior nursing and medical staff. Some staff could articulate the vision for their ward and service.
- Some staff told us of the inconsistent information given to them by senior managers, and that on occasions, their questions were not answered. One member of staff told us "it feels like we are the last to know what is going on".

Governance, risk management and quality measurement

- We saw that a number of governance meetings were held across the surgical services to highlight change to practice and present audit data.
- Minutes showed that audit data, as well as risks, were discussed.

Leadership of service

- Staff spoke highly of their managers to ward manager level, and had confidence in their leadership. However, they told us that they did not always feel supported by senior managers, which was reflected in the NHS staff survey.
- Staff told us that they sometimes saw the director of nursing on the wards, but did not think they had seen any other senior management on the wards.

Surgery

- Staff told us that matrons had had their clinical responsibilities changed a number of times in the last two years, and this had led to a lack of leadership continuity.
- The use of the Vanguard theatre to increase capacity was required, as the day surgery unit was commonly used for inpatient activity.

Culture within the service

- Staff we spoke with were open and honest about the challenges they faced, and how they were managing them.
- Staff were clearly passionate about the care they were providing, but not all were positive about the future. Staff told us that frequent reorganisation had led to instability in some clinical areas.
- Staff in one clinical area were dissatisfied with the management of their unit. They had asked to raise a question with the chief executive as to the future of the service, but they had been stopped by middle management from doing so. They felt disengaged from senior leadership, and concerned that their views were not considered important.
- Staff were clearly aware of the financial situation of the trust, and accepted that they would not receive resources to improve patient care, or to ensure innovation or improvement. The staff tried to ensure that despite this, patients received good care, and improvements were taken where possible.

Public and staff engagement

- We saw that response rates for the Friends and Family Test across surgical wards at the Princess Royal Hospital were below the England average.
- We saw that all surgical wards at the Princess Royal Hospital consistently scored higher than the England average for positive responses to the Friends and Family Test.
- The trust scored poorly for staff job satisfaction and motivation on the NHS staff survey when compared to the England average, and had a poorer response rate to the survey than the England average.

Innovation, improvement and sustainability

- We saw that the head and neck ward was delivering an excellent service to patients undergoing life changing surgery. Patients were cared for in a dedicated unit that had been refurbished, and offered privacy and dignity. Staff we spoke with demonstrated a clear vision, and had an excellent specialist knowledge of their specialty.

Critical care

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

Information about the service

The Princess Royal Hospital has an intensive care unit / high dependency unit (HDU/ICU) with a maximum of nine beds. The unit provides a mix of level 3 and level 2 beds. Level 3 are beds for critically ill patients, who are ventilated and have other complex care requirements. Level 2 patients are also critically ill and have complex care needs, but may not require ventilation. The unit can accommodate up to six level 3 patients in total. The intensive care unit and the high dependency unit admitted 332 patients in 2013/2014. The coronary care unit provided up to five beds, and admitted 935 patients between August 2013 and August 2014.

Intensive care consultants provided medical cover for the intensive care unit and high dependency unit from 8am to 5pm, Monday to Friday. Over the weekend, a consultant, who may be either an anaesthetist or an anaesthetist with additional experience / qualification in intensive care medicine, was available during the day, on-site, and during the evening and night on-call from home. A consultant cardiologist provided medical cover to the unit on-site six days a week, and on the seventh day there was an on-call arrangement with the Royal Shrewsbury Hospital.

Evening / overnight medical cover for the intensive care and high dependency units was provided by a registrar on-site, with a consultant on-call from home. The coronary care unit also had a registrar on-site during the evening and overnight, and a consultant on-call from home.

We visited the intensive care unit, the high dependency unit, and the coronary care unit. We talked with 13 patients, one relative and 15 staff: nurses; doctors; domestic staff; and managers. We observed care and treatment, and looked at five patients' records, who were receiving or had recently received care within the critical care wards. Before the inspection we had reviewed performance information about the hospital.

Critical care

Summary of findings

Critical care services were found to require improvement overall. There were insufficient, suitably skilled and experienced staff on the unit, which represented a significant risk to patients. When we highlighted the staffing shortfalls to the trust, they took immediate action to ensure that sufficient and appropriate nursing staff were available to care for patients in the intensive care unit (ICU), the high dependency unit (HDU), and the coronary care unit.

Critical care services were obtaining good quality outcomes, and patients received treatment that was based on national guidelines. The critical care service staff were caring and compassionate, and we judged that this domain was good.

The general capacity of beds in the hospital was a challenge. Bed capacity had also impacted on critical care services, both in the availability of the beds within critical care, and also on delays in discharging patients to other wards. Improvements were required to the leadership of the critical care services, to ensure that the management responded appropriately to staff, and that the service provided met national guidelines.

Are critical care services safe?

Requires improvement

We found that the safety of critical care services required improvement.

When we initially visited the hospital, there were insufficient experienced nurses and doctors to staff the intensive care service, and there were unsafe arrangements staffing the coronary care unit. We highlighted our concerns about staffing arrangements to the trust, who took immediate action to ensure that there sufficient and appropriate staff available.

Staff were able to report incidents, but a lack of feedback meant that appropriate actions were not being undertaken. There were comprehensive investigations into incidents that had resulted in serious harm, such as infections and pressure ulcers. There were appropriate systems in place to highlight the deteriorating health of patients.

The environment was clean and hygienic. Arrangements for medicines were generally appropriate.

Incidents

- There had been three serious harm incidents associated with the intensive care / high dependency unit which were reported to the National Reporting and Learning System (NRLS). These incidents related to three grade three pressure ulcers, between August 2013 and August 2014.
- We looked at the root cause analysis investigations (RCA) for these incidents. They were comprehensively investigated and were judged to be unavoidable. The RCA investigations identified how learning would be shared, and actions that would be undertaken to reduce the risk of similar incidents in the future. We also saw that required actions had or were being addressed.
- The hospital had a computer-based system for reporting incidents. All staff, including bank and agency, were able to report incidents, and were aware of incidents that required reporting. Staff we spoke with said that they had reported incidents, such as pressure ulcers, falls or

general concerns about care. Staff told us that they did not always receive feedback about incidents, and were not confident that actions would be taken in response to the incident.
- A ward manager told us that a feedback form had recently been introduced, which identified feedback given to staff.

Safety thermometer
- Information about the incidence of pressure ulcers, infections and falls was displayed on the coronary care unit, but not on ICU and HDU.
- The hospital safety information, which was updated monthly, showed that the ICU/HDU and coronary care unit were performing as expected for safety indicators.
- The units had low numbers of catheter urinary tract infections and falls. The number of pressure ulcers had recently increased; however, overall the numbers compared favourably with other similar trusts.

Cleanliness, infection control and hygiene
- Patients were cared for in a clean and hygienic environment. There was an identified cleaning programme, which was up to date.
- The cleanliness of the ITU/HDU and coronary care units were audited monthly. The ICU/HDU and coronary care units had scored 100%% when audited by an independent manager. Results of monthly compliance of staff with hand washing/hand hygiene audits identified that the ICU/HDU and coronary care unit had scored 100% compliance.
- Staff followed the trust policy on infection control. The 'bare below the elbows' policy was adhered to, hygienic hand-washing facilities and protective personal equipment was readily available, and used appropriately by staff.
- Hand gel was available at the entrance to the department, and at each bed space. Signs were visible throughout the units to remind staff and visitors about the importance of hand washing.
- We observed that intravenous medicines were being prepared by staff on a work surface behind the nursing station. This work surface was used for other activities, such as writing in patient notes and storing of paperwork. We observed one member of staff undertake setting up of an intravenous drug infusion in this area, which did not comply with infection control guidelines.
- The units had low infection rates for C. difficile and no MRSA infections in the previous 12 months.

Environment and equipment
- To ensure patient safety, appropriate checks on equipment were undertaken. For example, we observed checks to portable capnography used to check the location of breathing tubes by monitoring carbon dioxide in expired breath.
- We saw that the resuscitation equipment was regularly checked and when needed restocked; there was a record of when and who had undertaken this check.
- A buzzer system was used to enter the critical care unit, to identify visitors and staff, and ensure that patients were kept safe.

Medicines
- All controlled medication, high risk medication and associated paperwork were appropriately and safely stored.
- Medicines and intravenous fluids were securely stored in lockable cupboards.
- The medicines' fridge temperatures, including the minimum and maximum temperatures, were recorded daily. The temperature of the room/area where medicines were stored was not recorded within the wards/units we visited. A regular check on temperature provides assurance that medicines are stored safely, and their effectiveness is not adversely affected.
- The intensive care unit and high dependency unit did not have a dedicated pharmacist who provided advice and support to the units. Information provided to us from the trust said that the availability on a 0.6 whole time equivalent pharmacist was planned. This means that the hospital does not meet core standards for pharmacist cover to meet the number of level one and level two beds available. Intensive care core standards identify: 'pharmacy services are often overlooked despite clear evidence they improve the safe and effective use of medicines in critical care patients'.

Records
- The ICU/ HDU and coronary care unit used a combination of computerised and paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, and their treatment and care needs.

Critical care

- Within the intensive care unit and high dependency unit, nursing documentation was available at each bed space. Observations were checked and recorded at the required frequency, and when required, were escalated to medical staff.
- There were clear records of the treatment that patients had received, and any further treatment or follow-up they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were, whenever possible, asked for their consent to procedures appropriately and correctly. Frequently within critical care, patients are unconscious or not able to provide their consent. Staff were able to provide examples of how they acted in the patient's best interests when patients did not have capacity to consent, and whenever possible, consulted with their relatives. The Mental Capacity Act 2005 was adhered to appropriately.

Safeguarding

- Staff confirmed that they had received safeguarding awareness training, and confirmed actions that would be undertaken to keep people safe. Staff were aware of their safeguarding responsibilities.

Mandatory training

- Training information provided by the trust showed that 60% of nursing staff in coronary care had received mandatory training, and 79% of nursing staff in ICU and HDU.
- Staff confirmed that they received annual mandatory training in areas such as infection control, moving and handling, and resuscitation, although this had been difficult due to staffing challenges.
- Staff training and attendance was monitored by the ward manager and senior managers.

Assessing and responding to patient risk

- There was a critical care outreach team (one nurse each day) seven days a week, from 7.30am to 8pm for the management of critically ill patients in the hospital across all the wards.
- The hospital used the VitalPAC early warning score (VIEWS) escalation process for the management of acutely unwell adult patients. VitalPAC is a computerised assessment tool used to identify patients who were deteriorating. The VIEWS score alerted doctors and the critical care outreach team as to which patients were deteriorating and needed to be reviewed urgently. We saw that this ensured that staff provided early and appropriate treatment.
- Nursing handovers occurred at least twice a day, during which staff communicated any changes to ensure that actions were undertaken to minimise the risks to patients.
- Risk assessments for patients for pressure ulcers, falls and VTE were being completed appropriately and reviewed at the required frequency. Risks assessments identified required actions to minimise risks to patients.

Nursing staffing

- We found that nurse staffing numbers compromised patient safety on ICU, HDU and the coronary care unit. Nurse staffing numbers did not meet core standards for intensive care units.
- We found that the nurse on duty on the coronary care unit had to oversee the telemetry records (a system of cardiac monitoring) of patients accommodated on other hospital wards. Nurses told us that if the cardiac tracing caused concern they had to phone the ward, although there was always the risk that the line may be engaged.
- Nursing staff levels for the coronary care unit did not meet national standards for coronary care; there was one nurse on duty on the coronary care unit 24 hours a day, together with a health care assistant. We found that this unit was usually full, with up to five patients. The qualified nurse also had to oversee the telemetry records (heart monitoring records) of patients accommodated on other hospital wards. We told the trust that these staffing arrangements were unsafe. Since our visit, an additional nurse is now on duty in the coronary care unit. We visited this unit during our unannounced visit and we found that the additional nurse was on duty. However, long-term staffing plans were yet to be established and the matter is being kept under review by the trust.
- We found that nurses on ICU/HDU were usually allocated to provide one-to-one care for level 3 patients, and for one nurse to provide care for up to two level 2 patients. However, staffing shortages had meant that this was not always the case, and intensive care core standards were not being met. We highlighted our findings to the trust, who took action to ensure that sufficient nurses were available with immediate effect.

We visited the ICU/HDU as part of our unannounced inspection, and found that staffing levels were safe. However, long-term staffing plans were yet to be established, and the matter is being kept under review by the trust.

- We were told that there was a plan for a senior nurse on the day shifts (band 6 or7) to be supernumerary, but there was no plan for a senior nurse on night duty to be supernumerary. However, we found that there was frequently no supernumerary nurse on duty during the day either. Band 6 nurses we spoke with confirmed that there was frequently no supernumerary nurse available. Core standards for intensive care units identify that: a clinical co-ordinator should be on duty for units over six beds to provide clinical nurse leadership, and provide support and supervision to optimise safe standards of patient care. We highlighted this shortfall to the trust, who took immediate action to ensure that a senior nurse was supernumerary on all shifts.
- To maintain safe staffing levels, the ICU/HDU relied on temporary staff, such as bank and agency nurses. Nursing staff told us that the trust had a policy that agency nurses could not administer intravenous medicines without supervision from a permanent member of staff. This meant that staff had to leave the level 3 patient they were looking after to check and administer intravenous medicines with the agency nurse. However, since the trust has ensured that a supernumerary nurse is available 24 hours a day, this scenario has occurred less frequently, and so has reduced the associated risks to patients.

Medical staffing

- Medical care in the ICU/ HDU was led by a team of three consultants, who were intensive care-qualified. One consultant was mostly present on the units from 8am to 5pm, five days a week; however, consultants told us that this was getting increasing difficult to achieve, due to their limited availability. The trust has recognised this to be a risk to patient safety, and the scheduled care group risk register, and other actions to reduce risk, were being considered.
- The coronary care unit had appropriate consultant cardiologist cover.
- All potential admissions to ICU, HDU and coronary care were discussed with a consultant. All new admissions were reviewed by a consultant within twelve hours of admission, Monday to Friday, and mostly within twelve hours over the weekend. This ensured that the trust was meeting the core standard for intensive care, that patients are reviewed within twelve hours of their admission by a consultant.
- A registrar or middle grade doctor with intensive care experience was on duty between 10pm and 8am for ICU and HDU, and another registrar provided medical cover for the coronary care unit overnight. In addition, one consultant was on-call from home for ICU and HDU, and another consultant was on-call for the coronary care unit. The consultant for ICU/HDU may not be an intensive care consultant. Arrangements to ensure that consultants in intensive care medicine provide both day time and night cover must be addressed urgently.
- An intensive care consultant was present in the ICU/ HDU from 8am to 5pm, Monday to Friday. Out of hours, at weekends and nights, there was an on-call consultant rota to provide cover in critical care, but they might not be an intensive care specialist. The core standards for intensive care units identifies that “a Consultant in intensive care medicine must be immediately available 24/7, and be able to attend in 30 minutes”. The critical care unit was not meeting ITU core standards.
- There were appropriate arrangements for seven-day working for the coronary care unit. A consultant cardiologist provided medical cover on-site for the coronary care unit Monday to Friday, and then one day over the weekend. On day seven, the consultant was on-site at the Royal Shrewsbury Hospital and was contactable by phone, but would visit the site if required.
- The consultants on ITU/ HDU undertake ward rounds twice daily, Monday to Friday, and daily over the weekend. Over the weekend, cover was provided by a consultant anaesthetist, who may not have had additional experience in intensive care medicine. Consultants we spoke with told us that decisions were sometimes delayed until ITU consultants were available. This meant that there was a risk that patients may not receive timely treatment, and this does not meet good practice guidelines.

Major incident awareness and training

- The trust had a major incident plan and business continuity plan. The major incident plan identified different types and levels of incidents and responses required by the hospital’s staff. Staff we spoke with were familiar with their role within the major incident plan.

Critical care

Are critical care services effective?

Requires improvement

There were some positive areas of effective evidence-based practice and multidisciplinary working in critical care, but improvements were needed.

Seven-day working for some staff and services was being developed, but further development, in areas such as pharmacy services, were needed. There was appropriate availability of cardiologists to provide medical support to coronary care. However, the availability of an intensive care consultant over the weekend was insufficient to ensure that patients received appropriate review. There were appropriately experienced nurses in coronary care. However, the ICU/HDU did not meet the requirement for appropriate experienced and qualified nurses. The lack of a dedicated nurse for education did not meet core standards for intensive care to develop and improve nurse practice.

Evidence-based care and treatment

- The ICU/HDU and coronary care used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, and Faculty of Intensive Care Medicine guidelines, to determine the treatment it provided. Local policies were written in line with this.
- There were care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- The unit had an identified clinical audit programme to monitor adherence to guidance, and staff were delegated responsibility to carry out audits. For example, hand hygiene, commode hygiene and general cleanliness audits, in which they identified appropriate compliance.

Pain relief

- The records we looked at confirmed that patients had regular pain relief. Patients who we spoke with told us that staff ensured they had the pain relief they needed and were kept comfortable.
- There was no pain assessment score for patients who were unconscious or were unable to express pain. This meant that patients may not receive appropriate pain relief.

Nutrition and hydration

- Patients we spoke with said that they liked the hospital's food, there was a choice, and there was plenty for them to eat.
- Patients all agreed that they had a choice of drinks, and they were regularly offered to them. We observed that drinks were accessible to patients.
- Patients who were unable to either eat or drink received naso-gastric feeding within 24 hours of their admission to ICU and HDU.
- Staff reviewed records to ensure that there were appropriate arrangements in place to highlight the risk of dehydration.
- Dietetic advice was sought when required.

Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. The ICNARC data demonstrated that the hospitals critical care units performed better in outcomes assessed, such as unplanned readmissions, than other similar trusts. The areas in which the trust performed worse were patient's whose discharge was delayed for more than four hours, and out-of-hours transfers from the unit. This meant that frequently patients were kept within the critical care unit for longer than needed, and this may mean that a bed was not available for another patient. Historical information has shown that those patients who are transferred out of hours (between 10pm and 7am) are at greater risk, and also find out-of-hours transfers more distressing.
- Data given to the ICNARC identified that the hospital's ICU and HDU had performed worse than expected for the number of deaths within adult critical care when compared to other similar critical care departments.
- The coronary care unit used 'Patient Safety at a Glance' computerised records. This system enabled staff to clearly see the patient's treatment plan and progress, and also to show that referrals had been made to other professionals. Patient's observations were also recorded and monitored on this system.

Competent staff

- ICU/ HDU had 39% of nursing staff with a post graduate critical care qualification. This does not meet national guidelines that at least 50% of nursing staff should have this qualification.
- The ward manager told us that the trust was able to fund one nurse each year to undertake the post

registration qualification in critical care. The limited funding restricts the units capacity to provide assurance that sufficient and appropriately qualified nurses will be available.
- Nurses who were in-charge of the coronary care unit had a coronary care qualification.
- Nursing staff had an induction period, during which they were supernumerary for at least four weeks. The ward manager on ICU/HDU acknowledged that they had previously struggled to achieve this.
- All nurse competencies were checked by nurses against standards identified by the National Competency Framework for Adult Critical Care Units. Records we looked at confirmed this.
- Senior nurses told us that they had struggled to complete the required competency assessments due to staffing shortages.
- Staff told us that they did not have a dedicated clinical education nurse, although this need had been identified. Staff said that this role was undertaken by senior staff around their other commitments. The lack of a dedicated clinical education nurse does not meet intensive care nursing core standards.
- We spoke with doctors, who said that they felt supported, and they were observed to have excellent rapport with patients and other staff.
- 84% of staff in ICU/HDU and 83% of staff in coronary care had received an annual appraisal. Staff we spoke with confirmed that they had received an annual appraisal.

Multidisciplinary working

- There was a daily ward round, with input from nursing staff. Multidisciplinary team members such as physiotherapists, the pharmacist, and speech and language therapists, had a handover when they visited the unit.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy, and physiotherapy staff.
- Patients had an assessment of their rehabilitation needs, which was usually undertaken within 24 hours of admission to the unit, as required by best practice guidelines.
- The unit shared a team of 2.4 whole time equivalent (WTE) physiotherapists with other wards. A physiotherapist visited twice daily, to plan and deliver treatment to patients.
- All patients with a tracheostomy were assessed by a speech and language therapist. In addition, a dietician provided support to the units.
- Nursing staff reported that the ICU and HDU units provided effective care because of strong "team working".

Seven-day services

- Potential admissions were discussed with a consultant. Patients were mostly reviewed by the consultant within twelve hours of admission, although this could not be assured over the weekend. This does not meet ITU core standards.
- A physiotherapist was on duty at weekends; however, nursing staff told us that their availability was very limited, as they also covered several other wards.
- Radiology services were available for urgent X-rays and scans.
- The pharmacy was open on Saturday mornings, but not on Sundays. Outside of these times an on-call pharmacist was available. Staff said that pharmacy arrangements were not effective, and required improvement

Are critical care services caring?

Good

Patients and their relatives we spoke with said that staff were caring and compassionate. Staff built up trusting relationships with patients and their relatives, by working in an open, honest and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Compassionate care

- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients we spoke to were highly complimentary about all the staff in ICU/ HDU and coronary care. Relatives also told us that staff were caring and compassionate.
- There were appropriate arrangements in place to maintain patient's privacy and dignity. There were privacy screening/curtains around each bed space, with a note to remind staff to ask before they entered

Critical care

Patient understanding and involvement

- The nature of the care provided in a critical care unit means that patients cannot always be involved in decisions about their care. However, whenever possible, the views and preferences of patients were taken into account.
- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes. We observed a doctor speaking to a patient and explaining risks to them, and also assessing their capacity to understand, and their ability to make a safe decision.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support.
- A chaplaincy service provided valuable support to patients and relatives.
- Relatives told us that the consultant had talked with them after their loved ones admission. Relatives we spoke with said that they had mostly been updated, and had opportunities to have all their questions answered.

Are critical care services responsive?

Requires improvement

The critical care services required improvement to meet patients' needs. The hospital was challenged with the availability of beds, both throughout the hospital, and within critical care services. There were occasions when patients had to wait for a suitable bed in critical care services. In addition, a delay in the availability of suitable beds on other wards had given the units other challenges, such as mixed sex accommodation.

Access and flow

- Between 1 September 2013 and 31 August 2014, figures showed that the combined bed occupancy for the trusts critical care beds was 104%. This means that on one day a bed could be occupied by more than one patient. This is higher than the national average bed occupancy for critical care of 86%. The bed occupancy is also above the Royal College of Anaesthetists' recommended critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests that a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers that carry associated risks.
- The bed occupancy for coronary care was 94%.
- The ICU/HDU had recently had its capacity increased from five beds to six. However, as the unit had more beds than it was commissioned for, there had been occasions when the number of patients and their dependency had exceeded the number and skill mix of nurses available.
- Staff told us that the coronary care unit was always full, and there were usually patients waiting for beds to become available. We observed during our visit that within an hour of one patient's discharge, the bed was occupied by another patient.
- ICNARC data showed that:
  - Non-clinical transfers to other hospitals were similar to other comparable units.
  - The critical care unit performed worse than comparable units for out-of-hours discharges.
  - The critical care unit performed better than other comparable units for patients whose discharge from the unit was delayed for more than four hours.
- Between October 2013 to September 2014 one operation was cancelled due to the lack of availability of critical care beds (this may include ICU or HDU).

Meeting people's individual needs

- The critical care units provided care to people with complex needs. Staff told us that due to staffing levels, they sometimes experienced difficulties providing care for patients, who were confused and disorientated when weaning off ventilation and drugs.
- Translation services were available, both by phone and in person.
- Nursing staff had undertaken additional training to enable them to provide care and treatment to antenatal and postnatal mothers, since maternity care had moved to the Princess Royal Hospital.
- The hospital had no system to survey critical care patient's views on the care they had received and, when needed, make required changes.
- Staff demonstrated a good understanding of people's social and cultural needs, and explained to them how they could raise concerns or make a complaint.

- Due to lack of bed availability in the general wards, we observed patients being discharged directly home from ICU/HDU.
- Staff had arranged for the Red Cross to take a patient home, and visit them at home, following their discharge. We observed this to be good practice.
- There was a visitors' room available within the ICU/HDU. Facilities for relatives to stay overnight within the hospital were available.
- Patients we spoke with on the ICU/HDU unit confirmed that visitors could visit at any time. Visiting times were displayed for the coronary care unit. One family we spoke with confirmed that they had been able to visit at any time.

Learning from complaints and concerns

- We looked at the three most recent complaints for ICU/ HDU and coronary care. We saw that complaints were investigated, and the outcome of the complaint recorded, with any learning identified.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Information on how to raise concerns and make a complaint was on posters displayed on both the ICU/ HDU and the coronary care unit.

Are critical care services well-led?

Requires improvement

Critical care services required improvement to demonstrate that they were well-led.

There was a need to ensure that staff were listened to, and felt confident that required actions would be taken in response to their comments and any risks that were identified. Ward managers were clear about the core standards and the risks associated with the services they managed. However, there was an apparent lack of understanding, of the requirements and importance of core standards for ICU/ HDU and coronary care, by matrons and senior managers from outside the ICU/ HDU and the coronary care unit. The lack of required actions to ensure that core standards were met had compromised patient's safety.

Vision and strategy for this service

- Staff were aware and understood the vision and values of the trust. Staff were clear about their role and the behaviours that would achieve these values.
- Changes to the service, due to challenges of provision of two ITU/HDU units at both the Princess Royal Hospital and the Royal Shrewsbury Hospital, were under consideration by the executive team.
- There were changes to the provision of coronary care services and the provision of angiograms at the Princess Royal Hospital, to provide a more cost effective service.

Governance, risk management and quality measurement

- The ICU/HDU are part of the Scheduled Care Group division. They had monthly governance meetings, where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to staff in staff meetings, and also by displaying information on notice boards.
- The ICU and HDU managers encouraged staff to report incidents. Following changes to feedback arrangements, staff confidence on incident reporting had improved.
- Some, but not all, risks inherent in the delivery of safe care, were identified on the scheduled care risk register. However, the lack of timely actions, to address the risks identified, did not provide confidence that actions were being taken to protect people from harm.
- A root cause analysis was undertaken following each serious incident; the investigations undertaken were detailed, and identified actions to reduce the risk of further similar incidents in the future.

Leadership of service

- ICU/HDU and coronary care each had a consultant, who was the medical clinical lead.
- ICU/HDU had a matron (band 8), who also covered theatres, recovery and endocrine services. The matron did not have a specialist qualification in critical care. This does not meet the intensive care core standards.
- The ward managers and matron we spoke with said that they were supported by the divisional management and executive team, and felt that the director of nursing was approachable and supportive.

Critical care

- Ward managers we spoke with were clear about the core standards for the services they managed. We found that there was a lack of understanding of the requirements and importance of core standards for ICU and HDU and coronary care, by managers from outside the ICU and HDU and the coronary care unit.
- A band 6 or 7 nurse was in charge of each shift on ICU and HDU and coronary care; however, this role was usually in addition to providing direct patient care and was not supernumerary. Core standards for intensive care identify that there should be a clinical co-ordinator on duty 24/7, who is supernumerary, to provide clinical leadership and supervision.
- Most staff reported that their matron was visible and approachable.
- Staff said that when they did not have a supernumerary nurse in charge, the leadership of ICU/HDU was challenged. Since our initial visit, there is now a supernumerary nurse on duty 24 hours a day, and staff were more positive about leadership arrangements.

Culture within the service

- Staff working on ITU, HDU and the coronary care unit spoke positively about the service they provided for patients. But they felt that the quality of care they were delivering was compromised due to staffing challenges. This had resulted in poor staff morale.
- Staff were encouraged to complete incident forms or raise concerns by managers.
- Staff felt that these concerns were not adequately addressed or listened to by senior managers from outside the units.

Public and staff engagement

- The ward manager for ITU/HDU told us that they had felt supported since a change in division managers. The new division management team had identified a business plan to increase the bed capacity. However, it had taken from September 2013 to June 2014 for the plan to be accepted and agreement reached for the additional staff needed. There had been a subsequent delay in recruitment of suitable nurses despite the ongoing need for the bed. This meant that there had been a 15 month delay, from the time that the need was formally agreed, to the recruitment of nurses, a delay which had put patients at risk and staff at increased pressure.
- Staff said that they felt that senior managers from outside their wards/units had not listened to their concerns. Staff we spoke with did not feel actively engaged in decisions about their service.
- Several staff we spoke with identified improvements that were needed, such as staffing arrangements. Staff told us that their concerns had been shared with senior managers from outside the unit; it was not apparent that their concerns had been suitably escalated to the executive team.
- Staff said that they speak to patients and relatives about their views on the units. There was no formal system in place to capture people's views on the service provided.

Innovation, improvement and sustainability

- There were systems in place to encourage innovation and improvement from staff members across all disciplines.
- Staff could be nominated for awards for their achievements, and there was an annual awards ceremony. Staff who received achievement awards had their photograph and achievements recorded in the staff magazine. Staff told us about recent improvements to their practice, such as the use of new dressings to prevent nasal pressure ulcers for patients who needed nasal cannula.
- There were appropriate systems in place to review service delivery and, when needed, ensure that lessons were learnt, and appropriate actions taken.
- Staff and senior managers told us that the hospital had been historically financially disadvantaged, which had provided a challenge to the quality improvement of the delivery of the service.
- Staff said that just their normal duties were a challenge with the current staffing difficulties. We recognised that the sustainability of improvement was a considerable challenge.

Maternity and gynaecology

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

Information about the service

The Women and Children's Centre at the Princess Royal Hospital (PRH) includes gynaecology services, as well as a consultant-led maternity unit, and a midwifery-led unit (MLU).

PRH opened its gynaecology service on 29 September 2014, and the consultant-led maternity unit on 30 September 2014. Both services were previously at the Royal Shrewsbury Hospital; the Wrekin MLU has been at PRH since the closure of the previous unit in Wellington.

The consultant-led unit has 13 delivery rooms, including one with a birthing pool, which has a telemetric cardiotocography (CTG) machine, which can monitor the baby's heartbeat during labour in the pool. The consultant-led unit, when it was located at the Royal Shrewsbury Hospital, had 3,978 deliveries in 2013/14. Wrekin MLU had 362 deliveries in the same year.

The new consultant-led unit has the capacity to deliver for 6,000 women, and the trust reported a slight increase in deliveries since the unit opened.

There is a separate antenatal and postnatal ward for women. One bay within the postnatal ward is specifically for transitional care babies. The antenatal ward also has one bay to take postnatal women and their babies if the postnatal ward is full.

There are two dedicated theatres within the maternity unit, both of which can be used for elective and emergency procedures. The main hospital theatres are used for gynaecological surgery.

Community midwives are employed by the hospital, who care for women and their babies both antenally and postnatally; all community midwives are aligned to a GP practice.

We visited all inpatient areas of the gynaecology department and consultant-led maternity service. We talked to 23 members of staff; this included a combination of medical staff, as well as nursing and midwifery staff. We also spoke with eight patients and reviewed two sets of notes.

Maternity and gynaecology

Summary of findings

Overall, the services for women in maternity and gynaecology were good; however, some improvements are required in order that patients were prevented from avoidable harm. These include reviewing the number of staff available, as currently, staff are moved within the unit to meet the demand of patients, sometimes leaving staff cover on areas thin. The incident reporting and investigation process, as well as the shared learning, was inconsistent.

The service did not have a vision beyond the recent restructure or additional staff recruitment. We noted that data reported and monitored could not be relied upon, and the dashboard would benefit from broadening the areas it reported on. However, women we spoke with were largely satisfied with the care they had received, and found staff to be helpful. Staff felt supported by local management, but not by senior management.

Are maternity and gynaecology services safe?

Requires improvement

We found that the maternity and gynaecology service required improvement. We identified some areas of good practice, but also identified a number of concerns. We were concerned about staffing levels in each of the maternity inpatient areas. We were told by staff that there were insufficient staff allocated to each shift, and that on occasions, shifts were below the trust's minimum requirement, either due to sickness, or because midwives were transferred from the antenatal or postnatal ward to work on the labour ward, leaving their own ward short of staff. Although the trust had an escalation policy, this was not linked to the acuity of the women on the wards.

The trust had a system in place to report and investigate incidents; most of the staff we spoke with informed us that they felt they did not always have time to report incidents, unless they were serious or resulted in a negative outcome for the patient, and that they did not receive feedback unless they had been involved in the incident. We found that incidents were not always categorised appropriately.

Access and exiting from each ward area could only be gained by use of a swipe card. This meant that patients and the public could not leave a ward without the assistance of a member of staff. This was both time-consuming for staff, particularly in the evenings when there were no ward clerks. We saw that clinical records were clearly documented, and contained the required information, although we noted some records were not securely stored.

Although the staff we spoke with talked confidently about identifying safeguarding concerns, they were not all clear about the process for making referrals out of hours. We found that infection control arrangements were good, and there had only been one reported incidence of an infection in the monthly monitoring reports.

Incidents

- The Princess Royal Hospital reported a total of 137 incidents for maternity and gynaecology between July

2013 and July 2014. The Royal Shrewsbury Hospital, which includes the consultant-led service (which is now located at the Princess Royal Hospital) reported a total of 1,234 incidents; 12 of which were serious incidents.

- During 2013/14 there had been a total of 13 serious incidents reported across all locations.
- There were no 'never events' reported by the trust. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- Management informed us that all staff had access to report incidents on Datix, the trust's computerised reporting system, and that regular reporting of incidents took place.
- The majority of staff we spoke with informed us that they felt they did not always have time to report incidents, especially if they were busy. Staff informed us that if the incident was serious, or had resulted in a negative outcome for a woman or her baby, they would report this, but that if they were short of staff for example, they would not always report it, because they did not have the time. One member of staff told us that they did not report incidents because they did not know how to use Datix.
- We viewed the root cause analysis (RCA) reports of three serious incidents and one high risk incident; it was not always clear from the information available which location the incidents related to. We saw that each RCA provided a detailed account of the event, the outcome and the root cause of the outcome.
- Action plans were in place for each of the RCAs we reviewed; the action plans included details of the person responsible, a deadline, and confirmation that recommendations had been implemented. One of the RCAs recognised a fault, but the actions did not address the issues identified. This particular RCA related to a stillbirth due to Inaugural Intra-Uterine Growth Restriction (IUGR); the RCA had identified that measurements had not all been recorded and that this was an avoidable stillbirth. Yet learning did not address the points identified, and it was reported that antenatal care was positive. It was also noted that this incident was recorded on Datix as a severity of harm 'low', although we were subsequently informed that it was a high risk incident. We were told that, although high risk incidents were investigated, they were not reported to the commissioners or Local Supervising Authority (LSA)), unless a supervisory investigation is indicated. Incidents classified as serious were reported to the commissioners and LSA.
- We selected a random sample of incidents reported during the preceding 18 months; we noted that not all incidents had been categorised, and that some incidents had been categorised as 'low' when it would have been appropriate to categorise them as 'moderate' or 'high'. We requested an explanation from the trust with regards to this, and were provided with a spreadsheet which reported on the number of incidents, and whether they had been reviewed and approved. However, an explanation was not provided.
- A review of the maternity service was requested by the two lead commissioners for the trust. As part of the review, serious incidents reported by the trust were examined, due to the high number of serious incidents being reported. The review concluded that of the 23 serious incidents reported in 2012/13, only seven were 'true' serious incidents. This meant that the trust had been over reporting, and that they were now comparable with other trusts.
- The staff we spoke with told us that they did not receive feedback on lessons learned from incidents unless they had been directly involved.
- We saw that the Women and Children's directorate produced a quarterly newsletter, and that this included information about lessons learned from a serious incident. The majority of staff we spoke with, either did not mention this newsletter, or if asked specifically whether they received it, they confirmed that they did, but that it was too long and so they did not have time to read it. One member of staff did report that they 'scanned' through it.
- We were provided with perinatal mortality meeting minutes. The minutes did not record the names of persons present at the meeting. The minutes documented a chronology of the event, although we noted in one instance that, although the times were recorded, the date the incident occurred was not. We also noted that some minutes listed areas for discussion and considered things which could have been done differently, but this was not the case for all. For example, for one case it was reported that a possible contributing factor to the baby's death was pre-eclampsia. However, there was no consideration as to whether the mother's condition had been managed appropriately. We also

noted another case which reported that the mother's substance misuse could have been documented better, but the report did not state why, or whether the mother had been referred for support with their substance misuse.
- In the cases where discussion had been provoked and learning points noted, there was no action plan recorded.
- The minutes we were provided with were essentially a summary of the chronology and potential cause for each case. Minutes did not report on actions required, or consider trends in sub-optimal care.
- We were provided with a copy of the Annual Report of perinatal deaths for 2013/14. A total of 23 cases of foetal mortality (trust-wide) were reported during this period (two cases related to one set of twins). This study was carried out with an aim to identify the rate of stillbirths amongst Shropshire and Telford & Wrekin Primary Care Trust patients, and concluded risk factors were age of the mother, weight of the mother, smoking status, ethnicity and multiple pregnancies. The report solely focused on risk factors, and did not include a summary of root cause analysis investigations, or trends in sub-optimal care.

Cleanliness, infection control and hygiene

- We observed that every ward and department that we visited was visibly clean, and we saw staff regularly wash their hands and use hand gel between patients. The hospital's 'bare below the elbows' policy was also adhered to.
- There had been no reported cases of MRSA or MSSA bacteraemias for 2014/15; data provided was reported until the end of July 2014.
- We saw that the gynaecology ward had achieved the target of 95% for screening non-elective patients for MRSA for two of the four months reported on for the year to date. May and June were under the target at 94% and 90% respectively. Hand hygiene audits were reported at 100% for three of the four months, data had not been reported on for June 2014. There was one reported incidence of C. difficile in May 2014.
- Data for hand hygiene, peripheral line care, decontamination, commode cleaning, and completion of the environment checklist until September 2014 (before the transfer of the consultant-led unit and gynaecology services to the Telford location) demonstrated positive results for most areas of audit for 2014/15, with a small number of exceptions.

Environment and equipment

- We were told and observed that there was no anaesthetic room in the obstetric theatres.
- The security arrangements to go through doors within the hospital were restricted, and required a swipe card to gain access or exit from a ward or department. We were told that this posed problems for staff transporting patients in a wheelchair or on a hospital trolley, and that this also meant that patients could not exit the unit without a member of staff opening the door for them. This meant that staff time was taken up unnecessarily, and that additional staff were required to assist in transporting patients. This also posed a risk for patients and visitors needing to exit the building in an emergency situation. We were told that the doors would automatically open if the fire alarm went off.
- The staff we spoke with told us that they had enough equipment; however, the midwives we spoke with told us that since the move, it could often take a long time to locate what they wanted. Some of the midwives we spoke with told us that there were not always enough thermometers or observation equipment.
- Midwives reported that they had a sufficient number of CTG machines (CTG machines are used to monitor the baby's heartbeat antenatally and during labour).
- We reviewed the resuscitation equipment, and found that it was all present and in date, although checks should be performed daily; but we noted that some of the resuscitaires had days where checks had not been undertaken; this ranged from between two and six days over a 16 day period. Checks on the adult resuscitation equipment had all been performed daily.
- We were told that if equipment was faulty, it was repaired quickly.

Medicines

- All of the patients and women we spoke with told us that they had received pain relief as required.
- The staff we spoke with told us that there were no issues in obtaining pain relief or other medication for patients and women.

- We observed that medication was stored appropriately, and that from the sample of medication we reviewed, including controlled drugs, these had been recorded as administered in accordance with requirements.
- We noted that the keys for the medication cupboards were not labelled, which could cause confusion if drugs were needed in an emergency. We also noted that medication on the maternity unit was not stored in a drugs trolley, and so that each time a mother needed medication, a midwife had to go back and forth to the cupboard. There was no consistency between the list of medication maintained by the antenatal and postnatal wards.

Records

- We observed that the majority of patient records were stored securely, although we did see some records stored in an open area within the postnatal and antenatal wards, which were unmanned.
- The staff and women we spoke with informed us that all women were issued with a copy of their care plan, which they retained and took to appointments throughout their pregnancy.
- We reviewed a sample of patient records in obstetrics and gynaecology, and found that they had all been completed, with relevant clinical information, and signed and dated in accordance with guidelines.

Safeguarding

- The staff we spoke with told us that they had attended safeguarding training. We reviewed the Statutory and Mandatory Compliance Report dated July 2014.
- We noted that training attendance at Level 2&3 child safeguarding for clinical services staff and midwives had been well attended; however, training for adult safeguarding was less so, particularly for midwives, at 58% attendance.
- We looked at training attendance for staff working within obstetrics and gynaecology and saw that safeguarding children at level 3 had been well attended by medical staff, but safeguarding adults had 0% attendance. Nursing staff had a low uptake, with only 60% of staff having completed the training as at July 2014.
- The staff we spoke with were able to describe with confidence the types of incidents / signs which would give them cause for concern about a child or vulnerable adult's welfare, and which may prompt a safeguarding concern.
- The trust had arrangements in place to report safeguarding concerns via an 'alert' and / or referral to social services. It is the line managers responsibility to decide who makes the referral, as well as ensuring that other guidance is followed, as set out in the trust's policy.
- However, the staff we spoke with all had mixed views about how safeguarding concerns were managed if they were the first person to identify a concern and it was deemed to be an emergency. Most of the staff we spoke with told us that they called the hospitals own safeguarding lead with any concerns, or spoke with their line manager, and that out of hours, they would telephone social services directly. The majority of staff were not aware of a need to follow-up any calls made to social services by faxing a standard referral form.

Mandatory training

- All staff were required to attend mandatory training. We were told that the mandatory training requirements had been needs-assessed, and tailored to ensure professional updates and clinical skills were relevant to the staff member, according to their speciality and location. For example, midwives working at MLUs had additional life support training for neonates (NLS).
- From the data available as at July 2014, there was a mixed picture. Some mandatory training had been well attended, whilst others had not. For example, a low percentage of midwives had completed infection, prevention and control training, but this had been attended by a much higher percentage of medical staff, as well as nursing staff from gynaecology. Adult basic life support had not been well attended by any staff group, and there was no attendance record for any staff group for paediatric life support. Neonatal Life Support is course offered to Maternity and Obstetric staff. Of whom 70% had attended at time of this inspection.

Management of deteriorating patients

- There were specific care pathways for women who used the maternity or gynaecology services in accordance with their clinical and social needs. We reviewed a sample of these, and found that they were followed in practice.
- We noted that the maternity unit did not have a triage area; this meant that women who attended the unit unexpectedly were sent directly to the delivery ward out of hours, and this meant that time was taken from midwives working on the labour ward; women could

have been appropriately signposted via a triage system if one had been in place. We were told that the implementation of a triage system was being given consideration.
- We saw that appropriate records were maintained, and the department used early warning scores to monitor any potential deterioration in a woman's condition.
- A standard checklist tool was used in theatre to ensure that necessary precautions had been taken, and that procedures were in place.

Midwifery staffing

- The head of midwifery conducted a Maternity Services: Midwifery Staffing Level Audit, as at the end of August 2014. The report concluded that maternity staffing levels were being met, in accordance with birth rate plus (a nationally-recognised tool to determine the number of midwives required per number of women giving birth) recommendation of a ratio of 1 midwife for every 30 women who used the service.
- The report did not assess ratios per unit, and instead concluded that overall, a birth rate of 1:30 was being met. The Royal College of Midwives (RCM) recommends a ratio of 28 births to 1 WTE midwife for hospital births and 35:1 for birth centres and homebirth deliveries. As the trust does not record data by unit we were unable to determine if each unit was meeting these recommendations.
- We looked at the rotas for five shifts for the antenatal, postnatal and labour wards. We found that two of the five shifts for the antenatal and postnatal wards were worked by only two midwives. The labour ward had been staffed in accordance with agreed numbers for two of the five shifts, with an additional midwife for two shifts, and with one midwife short for one shift.
- We saw that there were a total of 43 staffing-related incidents reported between September 2013 and 15 September 2014. Incidents were not identified by area so we could not ascertain to which area these related. This was compounded by the recent move of these services to the Princess Royal hospital site.

Delivery Suite

- The delivery suite had 13 delivery rooms, including one pool room with two theatres. There were six midwives allocated to work each shift.
- The midwives and women's services assistants (WSAs) we spoke with told us that the labour ward was always very busy, and that it was their perception that even when they were fully staffed, they were still 'stretched', and that on occasions, midwives cared for more than one woman in established labour. One midwife told us "care is compromised when we're busy because we don't have enough time to spend with the women, but management do follow the escalation policy and pull midwives from other areas". It was the perception of staff that there had been an increase in the number of women attending the unit since the move, but that it had been extremely busy prior to moving to the new location. Staff told us that they hardly ever had time for a break.
- The maternity department did not use agency midwives, and that cover was always sourced internally through additional shifts for permanent staff, or via the bank.
- There was a dedicated theatre team for elective obstetric surgery; therefore, at present, midwives working a shift on the labour ward were also required to perform theatre duties for emergency cases. We were told that discussions were taking place to increase the number of midwives from six to seven.
- There were three WSAs per shift on the labour ward, who were required to support both elective and emergency theatres as a 'runner'; there was no dedicated WSA for theatres. We were told that the WSA establishment had increased from two to three since the move to the Telford site. This was because duties which form part of the role had been increased; for example, WSAs were now expected to serve meals at lunchtime, and this had previously been the responsibility of domestic assistants. The length of time required to transfer a mother and baby to the on-site MLU had increased due to the distance away from the consultant-led unit.

Postnatal Ward

- The postnatal ward had three midwives to cover each shift. There were 23 beds in total, of which 11 were side rooms. There were three, four-bedded bays, one of which was used for babies with transitional care needs.
- The staff we spoke with told us that the unit had been very busy since the move, and that the postnatal ward was regularly full. Many of the women and babies who stayed on the unit had high acuity, which meant that they required extra care and support.

- This was a busy ward; on occasions one of the three midwives was asked to work on the labour ward because it was busy. This meant that the postnatal unit was left with only two midwives. One midwife told us that they felt this left the ward 'unsafe' at times.

Antenatal Ward

- Some of the staff we spoke with from the antenatal ward also informed us that they were busy, and that they were often stretched, and that staff were regularly 'pulled' from their area to go to the labour ward. They told us that this impacted on the care they were able to provide to the women on antenatal ward. Although they were comfortable working on the labour ward, and it was important for their development, because it was unstructured and they did not know whether they would remain on the antenatal ward or be moved to the labour ward during their shift, this made them feel anxious about coming to work.
- The midwives we spoke with from both the antenatal and postnatal wards told us that sometimes it could be manageable if the ward was full and they were fully staffed, if the patient needs were minimal; and that it could be busier if the ward was not full, but the patient needs were higher. There were no tools in place to consider the acuity of patients and the staffing levels.
- The staff on the antenatal ward had maintained a record of all shifts where a midwife was transferred to the labour ward or the postnatal ward since the service opened on 30 September. We saw that to date, on 29 of the 48 shifts worked, midwives were transferred to work on the labour ward or the postnatal ward.

Nursing staffing

- We were told by the staff that we spoke with that the staffing levels on the gynaecology ward were adequate and sufficient to meet patient needs.

Medical staffing

- There was adequate medical staffing, and the number of hours of consultant cover provided, met minimum requirements.
- It was noted that a business case had been made for the appointment of additional middle grade doctors.
- Staff informed us that the consultant-led service at the previous location had had an issue with obtaining an anaesthetist on occasions, but that since the move to the Princess Royal Hospital, the obstetrics and gynaecology department had obtained their own dedicated anaesthetist.

Escalation policy

- The trust had an escalation policy in place, which outlined optimal level and sub-optimal staffing levels; however, this was not linked to acuity, and although it was not due for review until November 2014, it was no longer relevant, as the number of beds on each ward had increased.
- The staff we spoke with told us that management always tried to have the agreed number of staff on shift wherever possible, but that this did not always happen.
- We were told that the trust had never 'closed its doors' for maternity admissions. Some of the staff we spoke with told us that they thought there were occasions when it was their perception that it would have been safer to do so.
- We requested data on the number of times the service had implemented the escalation policy. It had been followed on twelve separate occasions between March 2013 and April 2014, whereby additional staffing was sourced.

Are maternity and gynaecology services effective?

Good

The maternity and gynaecology servicers were effective. We noted that there were arrangements in place to audit the care and services provided. Women received pain relief as required, and adequate arrangements were in place to ensure that women and their babies received nutrition and hydration.

Overall, outcomes for women were good, although some outcomes were not consistently achieved, and the data reported was not always accurately coded. Data was also not reported on by location, which meant that it was not possible to observe performance at a particular site, which could 'skew' the data at location level.

Evidence-based care and treatment

- The trust has an assurance midwife, who has responsibility for ensuring that all new standards and

published guidelines are reviewed and implemented. We were told that all new NICE and Royal College of Obstetricians and Gynaecologists (RCOG) guidance is reviewed by the assurance midwife, and benchmarked against the trust's current arrangements. A report is prepared for the governance committee, detailing the differences between the new guidance and current trust standards. Discussions are then held to decide whether change is necessary.

- We reviewed care pathways and patient records, and from the samples we reviewed found them to be compliant with the associated standards and local procedures.
- The staff we spoke with told us that they regularly received updates regarding changes to guidelines, and that these were also available on the intranet.
- A women and children's clinical audit plan is prepared annually; audits are completed by medical staff throughout the year. We reviewed the plan, which included local and national priorities. We saw from review of the plan that audits were of relevance, and progress had been made with the plan; although we noted that some of the audits had not been started, and others had been started but not completed in line with the timescales set at the beginning of the year.
- We reviewed two completed clinical audits. We found that one of the audits, 'Induction of Labour', stated its aims, methodology and results. The hypothesis was that there was an increase in the number of inductions, which correlated with an increase in the number of emergency caesarean sections. The recommendation from the audit was to re-audit in one year. The audit gathered data and confirmed the anticipated increase; however, it was unclear what had been learned from the audit, or how patient care could improve as a result.
- The second clinical audit we reviewed, 'Bleeding in post-menopausal women' clearly stated its purpose, with findings reported on required changes to local practice and the need to provide feedback to GPs. However, the action plan did not include all recommendations; action dates were not recorded for all recommendations, and responsibility had not been assigned.
- We saw that both audits had been presented at the Obstetrics and Gynaecology Audit meetings, although it was noted that there was no evidence that progress with action plans of clinical audits was followed up through the meetings.
- The trust had an audit midwife, responsible for overseeing assurance audits, which were undertaken by midwifery staff, and were separate to the clinical audit process. We were told that a review of both audit plans is undertaken to ensure that there is no duplication. The assurance plan includes re-audits of the 52 Clinical Negligence Scheme for Trusts (CNST) standards.
- We reviewed a sample of assurance audits, and saw that they clearly stated their aims, objectives and findings. One of the audits, a re-audit 'Audit of Care of Women in Labour' reported a small decrease in performance of staff in three individual elements of maternal observations in second stage labour. The recommendation was to address this with individual staff; however, there was no evidence that recommendations were shared with all staff to ensure generalised learning.
- We saw from review of the Women and Children's Assurance report, July 2014 that the fertility department had 21 audits scheduled for the year, most of which were enforced by the Human Fertilisation and Embryology Authority (HFEA). From the information provided, it was not possible to determine progress made with audits.

Pain relief

- The women we spoke with all told us that they had received appropriate pain relief.
- The staff we spoke with informed us that there were never any issues in providing the required pain relief for women, and that this was done in accordance with their wishes and clinical appropriateness.

Nutrition and hydration

- The women we spoke with were all satisfied with the meals they received, and the support they received for breastfeeding their babies.
- We noted that the unit did not have facilities to support women to make up their baby's bottle feed, if choosing to feed their baby on formula milk. Mothers were expected to bring in a 'ready-made' formula; there was some 'ready-made' formula available for new mothers if they had not brought their own. This meant that some mothers were not receiving direct support and advice, and were expected to purchase their own baby milk prior to coming to hospital.

Maternity and gynaecology

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery for all aspects of obstetrics and gynaecology. We reviewed a sample of patient notes, and found that consent forms had been signed where it was appropriate to do so.
- The trust had set procedures for assessing someone's capacity through the emergency and elective route.

Patient outcomes

- The maternity department maintained a Quality and Performance Dashboard, which reported on activity and clinical outcomes. Data was reported on at a trust-wide level, and by the Clinical Commissioning Group (the authority who funded the woman's care). Activity by location was reported on, but performance was not; therefore it was not possible to review and report on data by location.
- Overall clinical performance was equal to or above expected performance, with the occasional exception by month; for example, the vaginal breech rate had been slightly higher than expected for July and August, and the percentage of caesareans following a failed ventouse was high for July. We noted that the induction rate was higher than expected for August, and the rates of third and fourth degree tears for first time mums was higher than expected for July.
- The dashboard used a RAG (red, amber, green) rating system. It was unclear what the threshold was for performance against each on the report, which meant that the data could not be relied on in its current format.
- We noted that the clinical outcome for women from Powys Local Health Board was significantly poorer for the percentage of normal births, assisted births, forcep rate, induction rate, and 3rd or 4th degree tear for first time births; the still birth rate was also much higher for three of the five months.
- We also noted that although the dashboard provided activity by location, performance data was not reported on separately. This meant that it was not possible to distinguish between the care provided at each unit.
- One-to-one care in labour was reported at 87.3% for the year to date (until August) across all locations. This is above the trusts target of 75%. However, the Safer Childbirth Guidance 2007 states that 'maternity services should develop the capacity for every woman to have a designated midwife to provide care for her when in established labour for 100% of the time'. It was not clear why the trust had set its target lower than national guidelines.
- The dashboard did not report on maternity readmission rates, or unexpected admissions to NICU, or unexpected maternal admissions to ITU, one-to-one care in labour, or the ratio of midwives to births; it also did not report on the transfer rate of women from MLUs to the consultant-led service; all of which is helpful to review at a glance, to ensure that a full perspective of the service is monitored each month.
- We requested data on the transfer rate, but we were only provided with percentages of women who had delivered at the consultant-led unit instead of at their intended unit. Data was broken down by the stage of pregnancy at which they changed their mind, or when a clinical decision was made. The reasons were also reported on; however, it was not entirely clear for all categories whether this was during labour.
- Access to maternity services was consistently below the 90% target for the percentage of bookings with a gestation of less than 12 weeks and six days, and below the 75% target for the percentage of patients with access to the same midwife throughout their pregnancy.
- The management dashboard for gynaecology, colposcopy and fertility reported positive outcomes for patients receiving their first definitive treatment for both inpatients and outpatients for the year to date as at September. Although it was noted that there were a high percentage of patients on the inpatient waiting list with 'open' clocks in April and May.
- Fertility standards were mostly met, although the intra-cytoplasmic sperm injection (ISCI) damage rate and complete fertilisation failure IVF (in vitro fertilisation) were higher than expected in May and August respectively.

Competent staff

- The staff we spoke with all told us that they had received their annual appraisal and supervision, and that they found this process helpful. We saw that trust-wide data reported that 97% of staff had completed their appraisal by August 2014.
- To ensure that all midwives have had their competencies maintained up to date, the trust has reviewed and revised its 'rotation' arrangements for midwives. Previously, a proportion of midwives rotated

from MLUs to the consultant-led unit to update their skills, each rotation lasted one year. This arrangement had been in place for over 30 years. There was no consistency in the selection process, and therefore not all midwives rotated.

- We were told that the trust had recently developed a database of all midwives, to review when they had last 'rotated' to improve this process. From 2015, there will be two rotations each year for a period of three months each; rotations will be structured to ensure that all midwives complete a rotation.
- All members of staff are required to complete mandatory and statutory training. We were told that mandatory training had been needs-assessed according the member of staff's location and job role; for example, all midwives were expected to complete CTG training, and midwives at the MLUs were expected to complete neonatal life support training.

Multidisciplinary working

- The staff we spoke with reported good multidisciplinary (MDT) working, both internally and externally. Staff reported that medical and nursing/midwifery staff worked well together, and that the MDT handovers, which took place twice daily, worked well.
- We were told that external arrangements also worked well, and that there were good communications and links with local GPs, as well as social services; information was regularly received from social services regarding individuals, specifying any support they may be receiving or may need.

Seven-day services

- Out-of-hours services were available in emergencies. All women could report to the hospital in an emergency, either via A&E or the maternity reception. The maternity unit had scanners available, which could be used out of hours if necessary. During the day, there was an early pregnancy assessment unit or day assessment unit. Guidance on self-referral or GP referral was provided at their first appointment.
- We were told that the pharmacy service was available out of hours, using the on-call system if necessary.

Are maternity and gynaecology services caring?

Good

Women who attended the Princess Royal Hospital received good care. The women we spoke with told us that staff were busy, but caring, and that information had been explained to them about their treatment.

Compassionate care

- The women and relatives we spoke with all reported that they received a good standard of care from all members of staff.
- Feedback in the CQC maternity survey results reported positive findings overall for each aspect of maternity care provided.
- Gynaecology reported on the Friends and Family Test results as part of the ward-based quality key performances indictor report. There was a target of 75% for all patients to complete the test; this had been achieved in April and July, but a rate of 60% and 62% had been achieved for May and June. Although response rates were reported on, the report did not provide information on patient satisfaction.

Patient understanding and involvement

- The women we spoke with all reported that communication was good throughout their pregnancy, and that their partners had been involved.

Emotional support

- The trust had a bereavement midwife who was responsible for speaking with women and their families who may have been bereaved during or after childbirth, or may have required a termination due to medical reasons. The midwife offered support and advice to women and their families at specific stages, but was also contactable if needed. Information detailing various agencies who provide counselling support for women and their families was also provided.
- One person told us that they had experienced a number of miscarriages, and that although they had been provided with leaflets with information on access to counselling services, no one had taken the time to explain the information to her.

Are maternity and gynaecology services responsive?

Maternity and gynaecology

Good

Maternity and gynaecology services were responsive. We found that planning and delivery was good, and that access arrangements worked well, although discharge arrangements for women in the maternity department could be improved. In general, people's individual needs were met.

Service planning and delivery to meet the needs of local people

- The original consultant-led unit based in Shrewsbury was originally built in the 1960s with a capacity for 2,500 deliveries annually. The number of deliveries exceeded capacity in recent years and a plan was developed to move the service to the Princess Royal Hospital. We were told that there were extensive plans, and that the capacity of the new unit was built to accommodate 6,000 deliveries.
- We were provided with a draft business case for staffing for enhancing quality and safety in obstetrics; this was a follow-on from the original business case accepted by the trust board in November 2010.
- The draft set out staffing needs for the department, detailing where this had been met, and remaining gaps where additional staffing was still required. Gaps were reportedly for middle grade doctors, as well as theatre staff. The draft business case proposed that the remaining elements of the business case were phased over two years; 2014/15: Additional midwifery and theatre costs; 2015/16: Additional medical costs.

Access and flow

- Data for 2014 indicated that there had been an improvement in gynaecology patients receiving their first definitive treatment within 18 weeks, and the trust's target was regularly met for the year. This was an improvement on the previous year, where the target had not been consistently met.
- The trust had a set target of 90% for women with a gestation of less than 12 weeks and six days, making a booking. This was being met for the majority of months, with the exception of teenage pregnancies where performance varied from 69% to 86%.
- The maternity department had a day assessment unit, which was open 9am to 5pm, Monday to Friday. If women or their community midwife / GP had concerns about the baby they could access this service and be assessed by a midwife. Out of hours, and for women who perceived that they were in labour, they went directly to the labour ward for assessment. There was no triage system in place. This meant that valuable time was taken up by midwives who were working on the labour ward, which could have benefited women at a more advanced stage of labour.
- We were told that discharges on the postnatal ward could sometimes be delayed if women were waiting for medication or needed to see a doctor. There was no data available on delays in discharging women from the postnatal ward. There was no discharge lounge for women, which meant that beds could not become available until a woman had been physically discharged from the ward.

Meeting people's individual needs

- We were told that women who used the service, who were unable to speak English fluently, could access an interpreter service if required. An interpreter could be booked to attend antenatal appointments if necessary, a telephone service was also available. The staff we spoke with reported that this worked well when needed.
- We were told that there were information leaflets available in other languages if required. Leaflets in alternative languages were those made available by the Department of Health; these were accessible to staff via the intranet and could be printed for women as required.
- The staff we spoke with told us that if a patient who used the service had any specific needs, whether these were mental health, social needs, or safeguarding, staff would contact the trust safeguarding lead, or refer to guidance on the intranet for advice.
- We were also told that there was a multidisciplinary meeting held monthly to discuss midwifery patients with additional support needs, to ensure that their individual care plan was suitable.
- We noted that the postnatal ward did not have an area for women to make formula milk for their babies.

Learning from complaints and concerns

- We observed that a Patient Advice and Liaison Service (PALS) leaflet was available for patients who may want advice and support. We asked whether there was a

complaints leaflet, and were informed that there was no longer a complaints leaflet for patients, and that this had been replaced with a PALS leaflet. This meant that patients may not feel able to make a formal complaint.
- We reviewed a summary of complaints made between August 2013 and July 2014. There were no complaints relating to the Princess Royal Hospital during this period.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology service at Princess Royal Hospital was well-led.

There was a governance structure in place and arrangements for patients to provide feedback. Staff felt well supported by their immediate line manager but felt supported by senior management could be improved. The directorate had recently accomplished a major restructure of the service, moving obstetric led services to a new unit based at the Telford site. The vision for the next steps for maternity services was not yet clear.

We saw some positive examples of good governance, but we noted that reporting of data was unclear and could potentially be misleading, and minutes of discussions about performance could be improved.

Vision and strategy for this service

- The trust had recently opened a new purpose built consultant-led service at the Princess Royal Hospital. All consultant-led services at Royal Shrewsbury had moved to the new unit.
- A maternity services review was commissioned by the two local CCGs. The review focused on patient safety, quality of care, the sustainability of the hub and spoke model, and the sustainability of workforce numbers, alongside educational needs, the reporting of serious incidents, patient complaints and review of serious incidents. The review also considered the areas highlighted by the coroner following the outcome of an inquest into the death of a new-born baby within the county. Opinions of mothers who had received care, their partners and family members, were also sought. The review identified areas for development and implementation; this was approved in April 2014 and we saw that progress had been made with its implementation.
- The staff we spoke with were not as yet aware of what the vision was for the service beyond the recent reconfiguration.
- We requested a copy of the department/directorate's business plans. However, we were not provided with one.

Governance, risk management and quality measurement

- There were clearly defined committee arrangements in place. The directorate held a care group centre board (CGCB) which was attended by senior management and medical staff within the division, as well as other key individuals. Sub-committees which reported into the CGCB included a maternity governance group and a gynaecology governance group. The CGCB reported to the risk management executive committee; a direct sub-committee of the trust board.
- The CGCB received reports on human resources and staffing issues, as well as performance data for each division. We reviewed the minutes for August and September, and noted that discussions around performance were mainly around targets which had been met, or general information about what the targets were. There was little discussion recorded about targets which had not been met. We noted that in August, a quality and safety report was presented; discussion in the report stated that 'it was highlighted that there appeared to be a lot of red on the dashboard. Target levels and the 0% figures were discussed'. However, there was no record in the minutes about which targets were red, or whether they related to maternity or paediatrics.
- We noted through review of the dashboard that although some areas were coloured red, amber or green, it was not clear what the threshold was for amber. We also noted that for some months performance had been colour coded as green when the target had not, in fact, been met. This could easily be misinterpreted and not followed up. The dashboard could have been improved to include additional targets, such as the number of unexpected admissions to NNU (the neonatal unit).

- The divisional governance committees received regular reports on performance, patient experience, serious incidents, complaints, audits, risk register updates and infection control amongst other things, and we saw evidence of this in the minutes.
- A joint maternity and gynaecology feedback group for wider learning was also held every four weeks. Band 7 nurses/midwives fed into the governance groups. Each ward/department had their own individual team meeting each month.
- Each division maintained their own risk register, and there was a strategy in place outlining how this should be updated and monitored. We reviewed the risk registers, and saw that they had a clearly defined title, description, owner, each risk had been scored, and existing controls had been recorded along with any action required.
- It was noted that existing controls could sometimes be confusing where the risk had been on the register for a long time. It was not always clear what the current status was; for example, the risk around medical staffing cover had been added in 2010 and made reference to updates concerning the position which were not in chronological order; this meant that it was unclear what the current existing controls were.
- The staff we spoke with told us that there were monthly team meetings that they could attend, and these included a discussion around general issues affecting their ward. However, most of the staff we spoke with were unaware of how their department was performing against key targets, and they did told us that they did not receive feedback on lessons learned from incidents unless they had been directly involved.

Leadership of service

- The department had a clearly defined accountability structure. The care group director (also the head of midwifery) had responsibility for overseeing midwifery and nursing staff; the deputy head of midwifery and care group lead nurse, business manager and fertility manager all reported directly to the care group director. It was noted that reporting lines below this were not documented, although staff were aware of their immediate reporting lines.
- The care group medical director was directly accountable for the clinical directors for gynaecology and maternity. As above, staff were aware of reporting lines below this, but these had not been documented.
- The staff we spoke with all reported that they felt very supported by their immediate line management, and that they had good working relationships with all staffing groups. However, some of the staff we spoke with commented that they did not feel supported by senior management; that when it was busy, support was not provided. For example, one midwife who worked on the postnatal ward told us “when it’s busy, senior management just tell us to do more discharges. But we need to prioritise our clinical responsibilities”. This was not the perception of all staff; another member of staff told us that management were “lovely” and that this was “a saving grace”.
- Although some of the staff did not feel supported by senior management, they felt confident that if they needed to report serious concerns following the trusts whistleblowing policy, they would be listened to.

Public and staff engagement

- The Women and Children’s Care Group had recently implemented a patient experience and engagement strategy in September 2014. The strategy had been shaped by various mediums, such as complaints, focus groups, surveys and incidents.
- We saw that the Care Group had arrangements in place for patients to complete the Friends and Family Test, although the response rate was below the trust target.
- The annual staff survey reported that staff were dissatisfied with the level of communication between senior management and staff, and that it was not their perception that incident reporting was fair and effective.

Services for children and young people

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

Information about the service

There had been a review by the trust of the children's service that had resulted in changes to the configuration of the services. The review had been undertaken to ensure that the needs of the local population were met in a safe and responsive way. Services for children and young people consisted of a newly-built specialist unit: Shropshire Women and Children's Centre, which opened on 29 September 2014. The new facilities consisted of a 36-bedded children's ward, including three oncology beds and high dependency beds. In additional there is a 24/7 eight-bedded children's assessment unit. The neonatal unit had a maximum capacity of 22 cots. These were made up of six intensive/high dependency cots and , 16 special care cots. There were nine consulting rooms in the children's outpatients department.

We visited the children's inpatient and outpatient areas, and the neonatal care unit .We spoke with six children and ten parents. We also spoke with 30 staff, including consultants, doctors and nurses, play therapist, school teacher and administrative staff.

We observed care, and looked at four sets of care records of patients. We reviewed other documentation, including performance information provided by the trust.

Summary of findings

Services for children and young people were found to be good. Children received good care from dedicated, caring and well trained staff, who were skilled in working and communicating with children, young people and their families. There were processes in place for children's safeguarding, and concerns were identified and referred to the relevant authorities.

The trust had provided good flexible staffing levels, an adequate skill mix, and had encouraged proactive teamwork to support a safe environment. There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices.

Outcomes for patients were good, and treatment was in line with national guidelines. There were clear strengths in specialist areas in treating children. Staff felt valued and had clear lines of communication though the trust. Staff felt confident in raising concerns and felt listened to regarding ideas to improve services.

Services for children and young people

Are services for children and young people safe?

Good

Staff on the children's wards and the neonatal unit were very supportive of each other, and worked hard to provide safe care.

The trust had arrangements in place to monitor incidents, and staff were clear on their responsibilities relating to this. Procedures were in place for the trust to learn lessons from incidents, and staff were aware of trends associated with incidents.

Children's inpatient and outpatient areas were clean and tidy, and there was sufficient, appropriate equipment available for staff to deliver safe care. Staff and children had recently moved into the new Shropshire Women and Children's Centre, which was built to address issues around safety and capacity of facilities, and improve patients' experience.

Staffing levels were appropriate at the time of our visit .The trust had procedures in place to monitor staffing requirements based on acuity, and had protocols in place to support decision-making.

Incidents

- The hospital had systems in place to make sure that incidents were reported and investigated appropriately. We saw that there had been a total of 39 patient safety incidents reported for quarter 2. We saw examples of where incidents had been reported; a full investigation was carried out, including looking at the root cause of why the incident happened in the first place. We also saw evidence that systems were put in place across the women and children's care group to prevent the incident from happening again. We were shown a root cause analysis investigation, and found it to be comprehensive, and it included areas of notable practice and an action plan for the required improvements.
- We discussed the management of incidents with nursing and medical staff of all grades working in the children's ward and in the neonatal unit. All staff spoken with confirmed that they were able to enter data onto the Datix system and had received training.
- The trust shared with us the report from the paediatric clinical governance meeting held on 17 September 2014, which demonstrated that prominence was given to discussing incidents, and ensuring that they received the correct level of attention.
- There was evidence, in staff meeting minutes, of incident reports being shared. These meetings occurred at monthly intervals.
- The women and children's care group had recently implemented a newsletter to support the sharing of information more widely. The newsletter's purpose was to inform staff of what was going on in the service; some of the key areas of information shared included incidents, risk register and audit.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were assessed and monitored monthly, and monitored through trust dashboards. At the time of our inspection, children and young people's services were achieving trust compliance standards for cleanliness and hygiene.
- The areas we visited were clean. Hand-washing facilities were readily available, and we observed staff adhering to the trust's 'bare below the elbows' policy.
- We found infection prevention policies and procedures in place for supporting winter arrangements on the children's ward. For example, during the winter months they could expect more admissions with children suffering from chest infections. We found that staff were aware of these plans.
- The importance of visitors cleaning their hands to improve infection control was emphasised. We saw parents use hand gel on entering the ward.
- Staff identified that the new neonatal care unit had increased isolation facilities, and supported flow through the department, which was specifically designed to minimise the risk associated with healthcare associated infections.
- All the toys we saw throughout the inspection were clean and intact.

Environment and equipment

- The environment within children and young people's services was fit for purpose, and offered a variety of age-appropriate equipment, including accessible facilities.
- Age-appropriate resuscitation and emergency equipment was available, and was checked regularly.

- Entrance to the children's areas was secure, with access by swipe card, or entry granted by a member of staff. All staff wore appropriate identification.

Medicines

- A paediatric pharmacist attended the children's ward and neonatal unit daily, and reviewed prescriptions, and made recommendations.
- Cytotoxic drugs for oncology patients were kept securely, together with the notes for those patients.
- We checked that medicines were safely stored. We saw that all the drug store cupboards were locked, records of controlled drugs had been completed, and stock checked daily. Controlled medicines were stored in separate locked cupboards, and were double checked by qualified nurses. Where medicines needed to be kept in fridges, the temperature of the fridges was checked consistently every day.
- There was an established audit programme across children and young people's services, including drug omission, medicine security, storage of medicines and antimicrobial prescribing.
- Where medication administration errors had taken place, we saw evidence to show that they were reported and investigated in line with the trust's incident reporting procedures. Where necessary, appropriate action was taken to prevent their recurrence.

Records

- Records were kept confidential on the wards, and stored in secure cabinets.
- We looked at the records for four patients and found them to be accurate and legible. Information was easy to find.
- Information included the time that patients entered the hospital, the treatment received, advice provided, and the names of the doctors and nurses who attended to their needs.
- Observation sheets were available for different ages of children/young people. These forms were comprehensive, and included pain scores and the paediatric early warning scores. In the notes we looked at, we found that these observation charts had been completed consistently.

Safeguarding

- The director of nursing led safeguarding arrangements for the trust. The trust had clear governance and quarterly reporting arrangements in place for safeguarding, which included both children's and adult's services.
- The trust had a dedicated safeguarding team, which included clinical nursing staff. The team were able to support staff across both hospital sites, keep them informed on safeguarding issues, provide training across the trust, and to link directly to other areas of the trust where children are seen, such as accident and emergency departments.
- The safeguarding team trained individual ward nurses to be safeguarding link nurses within their own clinical area. These link nurses acted as an additional resource for their colleagues, and were able to assist with training.
- Procedures were in place to obtain the advice and support of a community paediatrician 24 hours a day, which was in line with best practice. When necessary, child protection medicals were held in dedicated clinics, and by staff who were specially-trained to perform them.
- The electronic patient administration system had the facility for alerts to be displayed for any child where safeguarding concerns were already known. The named nurse for safeguarding children told us that the local authority would notify the trust when/if information needed to be updated.
- Medical and nursing staff were trained to level three in children's safeguarding, as recommended in NICE safeguarding guidance. An up-to-date training register was held by the safeguarding team. We saw evidence to show that 96% of staff had completed this training, and it was up to date. Those staff who had yet to complete it, or where it required updating, had dates scheduled for their training.
- A safeguarding policy was in place across the trust. We saw that the trust's staff intranet had a dedicated page relating to safeguarding, which included useful links for staff to access, such as policies, emergency contact numbers and referral forms. The staff we spoke to all knew how to access the policy, were able to explain the different types of abuse, and how they would refer a child should they have any safeguarding concerns.
- The trust had appointed an Independent Domestic Violence Advisor (IDVA). The post had been

substantiated through funding from the Police Crime Commissioner due to excellent outcomes recorded by the trust. We were told that referrals from the trust to the Multi-Agency Risk Assessment Conference (MARAC) had been endorsed as excellent practice by the Co-ordinated Action Against Domestic Abuse (CAADA). CAADA is a national charity supporting a multi-agency and risk-led response to domestic abuse.

Mandatory training

- The trust held central mandatory training records for all wards and departments, and had a target to achieve 75% compliance with statutory and mandatory training. Data provided by the trust before our inspection indicated that this target had been achieved for nursing staff, with 63% compliance for medical and clinical staff.
- We looked at the training records for the children's assessment unit (CAU), and they showed that all staff were either up to date with their training, or had training days scheduled.
- The staff we spoke to all confirmed that they were up to date with their mandatory training. They told us that staff received two days training every year, which covered all aspects of their statutory and mandatory training. They also told us that they were fully supported by their manager to attend any relevant training.

Management of deteriorating patients

- A paediatric early warning score (PEWS) system was in place on the children's ward, based on the NHS institute for innovation and improvement PEWS scoring system. This tool supported early identification of children at risk of deterioration.
- PEWS assessments had been completed in the four care pathways we reviewed.
- Nurses explained the process of reviewing the scores, and the guidelines followed for alerting medical or senior staff to changes in the score, which indicated that a child's health was deteriorating, so that remedial action could be taken.
- Emergency care protocols were well embedded, and the emergency response team could be summoned quickly.
- Staff were able to explain the process for calling for help in an emergency.
- We were told that child and adolescent mental health services (CAMHS) were not available after midday, and were also difficult to access out of hours, such as at weekends. Relevant children presenting to the emergency department out of hours had to be admitted to the children's ward and looked after by ward staff until an assessment could be arranged. The child would have to wait until the next day if admitted after midday, or wait until after the weekend if admitted on Friday afternoon.
- The neonatal unit is part of the Staffordshire, Shropshire and Black Country Newborn Network. The unit is designated as level 2+ and is able to care for all newborn babies other than the extremely premature or those with specialist, usually surgical, needs. In such cases, the network provides a retrieval service to the higher level (Level 3) units at Stoke and Wolverhampton and Birmingham. We saw that the protocol and Transfer of Children Pathway was very detailed, and mitigated risks to babies while being transported.

Nursing staffing

- The safe staffing dashboard was displayed in the children's ward, neonatal unit and in the assessment unit. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix on the day of our inspection.
- Where there were shortfalls in staff due to sickness or annual leave, staff within the particular clinical area would be flexible and cover shifts. Where this was not possible, bank staff were used, and as a last resort, agency staff would be used. Procedures were in place to request additional staff.
- An acuity tool was used across the trust, which used clear descriptions of a child's care needs and the corresponding level of staffing required to care for those needs. The acuity score was also linked to the paediatric early warning scores.
- Staff in these units were all part of the same rota, and children were cared for by those with a recognised children's nursing qualification.

Medical staffing

- There were 20 consultants working across the trust, each with several lead responsibilities.
- The consultants were supported by registrars and junior doctors. Consultants were available overnight via on-call arrangements. Nurses and doctors told us that consultants were always available 24/7, and that they were always able to contact teams and get support. Junior doctors reported that they had good training and support from their senior consultants.

- The doctors on the neonatal unit had effective links with the postnatal ward, and had oversight of babies on that ward.

Major incident awareness and training

- All the staff we spoke with were aware of the major incident and business continuity policy, and understood their roles and responsibilities within a major incident.
- We saw a copy of the trust's major incident policy. The action plans were specific to different roles and level of responsibility, and identified the person responsible for leading and co-ordinating the responses to a major incident.

Are services for children and young people effective?

Good

Children were treated according to national guidance. The services had an annual clinical audit programme to monitor that guidelines were being adhered to. The service audited their performance against national guidelines, and protocols for common conditions were up to date.

Children were cared for by a multidisciplinary team of skilled and dedicated staff. Consultant presence and support was provided over seven days.

Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH).
- Appropriate standardised care pathways were in use in keeping with the relevant National Institute for Health and Care Excellence (NICE) clinical or nursing guidance.
- Policies, procedures and guidelines were available to all staff via the trust intranet. Staff we spoke to knew how to access them when necessary, and quickly found a random number of policies that we had asked to look at.

Pain relief

- We did not observe any children who required pain relief during our visit. Staff told us that pain control included age-appropriate methods.
- The trust did not have a dedicated paediatric pain management team. We were told by staff that a general pain management team, which covered both adults and children, was based at the hospital and would provide support when necessary.
- The play specialist team were available in each ward and department, and provided valuable distraction therapy for children undergoing different procedures.
- Children and young people told us that they received pain relief medication when they needed it. The parents also confirmed that the staff worked hard to make sure that their children were not in pain.

Nutrition and hydration

- The children's ward operated a protected mealtimes policy, both for the lunchtime and evening meals. This meant that children and young people could eat without being disturbed by staff on ward rounds or visitors, except for parents and siblings. We saw that this was observed by staff on the ward.
- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment on admission.
- Children and young people were able to choose what they wanted to eat from a menu. If they did not like what was on offer, parents were allowed to bring in food for them. Where their condition permitted, children were also allowed off the ward with their parents to visit the coffee shop or the main hospital shops.
- There was support from paediatric dieticians, who were available for specialist advice and support, with special diets and feeds. The staff were aware of this information, and how and when to access the dietician service. The staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- The records we reviewed during our inspection showed that any fluid or dietary intake was monitored and recorded where necessary.
- Records confirmed that children on the CAU were provided with meals and drinks at regular intervals depending on their symptoms.
- On the neonatal unit a designated special milk fridge and freezer was used for mothers to store expressed milk. Milk was clearly labelled, and the fridge was clean, and records confirmed that this was kept to a safe temperature.

Services for children and young people

Consent

- Parents were involved in giving consent for examinations, as were children when they were at an age to have a level of understanding.
- We observed how staff talked and explained procedures to a child in a way they could understand without getting frightened. Staff were aware of Gillick competences in relation to consent for young people of less than 16 years of age, and followed these when necessary.

Patient outcomes

- The children's service took part in all the national clinical audits that they were eligible for.
- The trust's paediatric governance group reviewed compliance with NICE guidelines, and the participation in national audit completed by the children's service. For example, we saw that the Women and Children's Care Group had benchmarked 42 NICE quality standards.
- We saw a copy of the 2013/14 neonatal service performance benchmark report, and noted that the trust had scored highly against the five benchmarked standards chosen for measure. For example, the standard is 100% for all babies of 28+six weeks gestation having their temperature taken within one hour of delivery. The trust scored 100% against this standard.
- The trust performance in national audits of paediatric asthma and diabetes was in line with national averages.
- Rates of multiple emergency admissions was higher than the England average for diabetes and asthma in the ages 1–17 category, and asthma and epilepsy for the under age 1 category.
- Emergency re-admission rates, across the trust, within two days of discharge were higher than the England average for elective cases in both age categories.
- Action plans were in place for each of the audits completed, regardless of whether performance was better or worse than average. This meant that the trust was proactive in taking steps to continually improve the effectiveness of the services provided to babies, children and young people.

Competent staff

- We spoke to several newly-qualified nursing staff, who had been employed as part of the trust's latest recruitment drive. They told us that they had received corporate induction, which they felt gave them the appropriate information for the trust as a whole. It also included some of the mandatory training that they were expected to complete. They told us that they had a very good ward induction, and were then able to work on a supernumerary (not included in the ward staffing numbers) basis for four weeks, to allow them time to settle into the ward and the specialty. We saw excellent examples of comprehensive competency-based preceptorship and orientation programmes for new staff within the neonatal and children's ward.
- Staff told us about the supervision arrangements in their own areas. All the staff we spoke to told us how well supported they felt by their ward teams, their managers, and the senior nursing and managerial staff within the Women and Children's Care Group. All the staff spoken with confirmed that their appraisals were up to date. For example, 96% of staff on the children's ward had received appraisal in the past twelve months.
- The medical staff we spoke to all confirmed that they had received an appropriate induction, both to the trust and the Women and Children's Care Group, when they started work. They told us that they received good training opportunities, and we saw evidence of this, with dedicated teaching slots and weekly specialist registrar training, such as on paediatric rheumatology and an introduction to community paediatrics.

Multidisciplinary working

- We observed multidisciplinary team (MDT) working throughout our inspection.
- Although nursing, medical and therapy handovers were undertaken separately, there were weekly MDT meetings, represented by a range of staffing groups, including education and social services.
- Nursing and medical staff we spoke with told us that there were very good physiotherapy and occupational therapy services available.
- The trust had access to the support of a community specialist paediatric psychologist, if necessary.
- GPs had access to consultant paediatricians for advice and support.
- A neonatal outreach team, linked to the community children's nursing service, enabled safe, early discharge of very small or sick babies.
- There were strong external links with a number of local authorities, including in Wales, and regular contact with safeguarding leads and social workers.

Services for children and young people

Seven-day services

- There were consultant ward rounds seven days a week on the wards, and they were available out of hours through on-call arrangements.
- The children's ward operated a service 24 hours a day. The children's assessment unit (CAU) was also open 24 hours a day, seven days a week.
- There was access to imaging services and pharmacy support out of hours, and at weekends, through an on-call system.
- Physiotherapy services were available seven days a week, with a physiotherapist visiting the children's ward twice a day. Out-of-hours support was available through an on-call system.
- Outpatient clinics were held Monday to Friday.

Access to information

- Information on specific health topics, and information on how to access hospital services, were available for people to use.
- The CAU and outpatient areas had trust policies and procedures available, which were accessible to staff on the trust's intranet.

Are services for children and young people caring?

Good

Babies, children and young people and their families were treated with compassion and kindness. Parents and relatives spoke highly of the care given in the children's ward, neonatal unit and outpatient clinics.

We saw that staff spent time with children, young people and their parents to make sure that they understood the care the patient was to receive.

Compassionate care

- Throughout our inspection we saw staff interacting positively and in a friendly manner with children and families.
- We observed staff welcoming new parents to the neonatal unit to see their baby for the first time. Staff demonstrated understanding about the parents anxieties and put them at their ease.
- We saw staff treating babies on the neonatal unit with gentleness and compassion. They spoke to the babies as they delivered care, explaining what they were doing and why.
- Telephone calls from parents were answered promptly and with respectful politeness.
- Children, young people and their families spoke positively about the care they received. One parent told us that the "staff are very welcoming and nothing seems to be too much trouble".

Patient understanding and involvement

- Staff made sure that children and young people and their parents were involved in planning the care provided.
- Support from a play specialist was available to support children to understand their illness and any procedures. They were able to offer dedicated time to individual patients, and help patients to use the services' facilities. These included a playroom and an outdoor play area, which patients could use, with appropriate staff supervision, which meant that patients were able to leave their wards.
- We observed that members of staff talked with children and young people at an appropriate age-related level of understanding.
- Spiritual and cultural information was collected within the child's integrated documentation. A staff member told us that children's cultural needs were accommodated in areas such as diet; for example, halal and kosher meals could be obtained for children.
- A young person and their parent told us that they had been given the opportunity to speak with staff, to ask questions, and had been kept informed of what was happening.

Emotional support

- The clinical lead for children's services told us that referrals for assessments for anxiety and depression were made to the clinical psychologist, based in the community.
- Paediatric specialist nurses, such as diabetic, epilepsy and child protection nurses, were available for parents and staff to access for support and advice, should they be required.
- The outreach team offered support for children, young people and families in the home setting.
- Support from the chaplaincy was also available if required.

Services for children and young people

Are services for children and young people responsive?

Good

There had been a review of the children's services that had resulted in changes to ensure that they were safe and responsive to the needs of children and young people and their families, and clinically sustainable.

Parents told us that they had the information they needed about their children's conditions and about treatment.

Information from the trust demonstrated that the service responded to children and young people about individual complaints or concerns.

Service planning and delivery to meet the needs of local people

- On 29 September 2014, changes to the service provided at the Princess Royal Hospital were implemented after a review into the future of women and children's services. The Shropshire Women and Children's Centre opened at the trust, and the centre was the main inpatient facility for women and children in Shropshire, Telford & Wrekin, and mid Wales.
- During periods of increased admissions or staff shortages, the trust had contingency arrangements in place to ensure that children and young people were cared for in a safe environment.
- The implementation of nursing acuity scores supported staff, to demonstrate clinical and staffing requirements for the children's unit.
- The service was, at times, supporting children who required services external to the trust. This resulted in delays in discharge, which were out of the trust's control. Staff told us that children and young people sometimes stayed in hospital longer due to a lack of availability of mental health services.
- The children's outpatient department provided a supportive age-appropriate environment, offering a range of activities for children and young people. There was a designated teenage area, with health promotion materials available.
- The trust had funded the training of advanced paediatric nurse practitioners, with specialist training to enable them to assess, manage and provide treatment, including prescribing for a wide range of common, self-limiting paediatric illness.

Access and flow

- At the time of our inspection visit, the Shropshire Women and Children's Centre had only been open for two weeks. We were therefore unable to ascertain how many children were seen and treated at the hospital.
- The records we looked at during our visit showed that the admission and discharge paperwork and checklists had been completed appropriately.
- The children's outpatients unit told us that there was no waiting list to see paediatric consultants, and all children were seen quickly following their initial referral; however, comparative data was not available.
- Discharge information was communicated to the child's GP, as well as their health visitor or school nurse.

Meeting people's individual needs

- Each ward and department catered for the needs of children. This included ensuring that there was enough space by each bed or neonatal cot for a parent to visit comfortably.
- There was a playroom and schoolroom, and outside play space was available off the main children's ward. Staff stated that the service was flexible enough to meet the needs of all children admitted to the ward, regardless of complex physical needs.
- A learning disability nurse specialist was available within children's community services, to provide advice and support to children with a learning disability. They also provided advice and support to staff in order to meet these patient's needs. Staff spoken with knew how to contact the learning disability nurse.
- Staff we talked with were aware of how to access a telephone translation service or face-to-face translator.
- A play team was able to provide qualified play specialists and play assistants to children's services, in addition to a playroom on the children's ward. The play team were informed of all planned admissions, and involved in multidisciplinary ward rounds as necessary.
- The children's outpatient clinics were light and bright, and had good play equipment.
- The trust provided teachers and a classroom, where children who were in hospital for longer than a specified

Services for children and young people

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff told us that they would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- Complaints leaflets were available at the entrance to the hospital, and in the ward and units.
- The new children's centre had been open for two weeks at the time of our inspection, and had not received any complaints.
- We saw that monitoring and practice reviews were discussed at the patient safety and experience quarterly meetings. Staff were aware of complaints management practices, and received feedback through meetings and newsletters to improve practice.

Are services for children and young people well-led?

Good

Services for children and young people were well-led. Ward level leadership was found to be effective and well managed. There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. Staff felt that they had been kept informed of trust changes and improvements, and that good communication was established.

Vision and strategy for this service

- Staff were familiar with the trust's vision and values. These values were now incorporated within the corporate induction and appraisal process, and staff told us that they understood them.
- The majority of paediatric staff understood the vision and strategy for developing the paediatric services, and said that there had been appropriate consultation with staff.
- We saw through minutes of meetings and newsletters, and from staff we spoke with, confirmation that they had been consulted with regard to service developments and design plans, such as the move of children's services to the new Shropshire Women and Children's Centre at the hospital.

Governance, risk management and quality measurement

- Monthly ward to board quality matron reviews were completed and monitored. These included monitoring comfort round checks, speaking with the patients, ward cleanliness, and patient and parent knowledge and understanding of their condition and treatment.
- One member of staff we spoke with on the children's ward told us that they were aware that 'quality walks' had been undertaken on the ward by the ward manager. We saw that a patient environment checklist was completed during these quality walks.
- There was a governance lead for the Women and Children's Care Group, and governance and risk management were being developed within the new service.
- Audit programmes were in place for monitoring standards of care, and these were carried out effectively throughout children and young people's services.
- There was a positive culture around reporting of incidents and learning lessons. The trust recognised the importance of staff reporting concerns.

Leadership of service

- We looked at copies of board papers, governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that there were management systems in place which enabled learning and improved performance, and were continuously reviewed where required.
- We saw that the paediatric leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients.
- Staff told us that there was visible leadership across the organisation to support the strategies, and senior managers were visible in the department for day-to-day operational management.
- Ward managers we spoke with also said that they felt supported by senior management, and that if they raised any concerns about the service, they would be listened to.

Culture within the service

- Staff told us that there was a positive culture within teams, and that staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care to children.

Services for children and young people

- The staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff felt able to raise any concerns.
- We saw a copy of the women and children's staff newsletter, which detailed that complaints and serious incidents were discussed, to enable learning between and within teams. Staff told us that details of incidents were shared across the trust.

Public and staff engagement

- Staff told us of good engagement in the service. They had been kept informed of service changes. They were able to continue to work for the trust, and had been able to transfer to the Princess Royal Hospital when children's inpatient services were removed from Shrewsbury.
- Focus and public meetings had been held for people about the changes to children's services in the trust.
- A trust-wide patient experience survey for March 2014 showed that 100% of paediatric patients felt that they had been treated with dignity and respect, and 88% of patients felt that they had been treated with kindness and compassion.
- Children and young people's services had introduced 'tops and pants' feedback, aimed at getting children and young people's views in a fun, interactive way. This was a system whereby children used cut-out paper tops to represent what was good about the service, and cut-out pants for what was bad about the service.
- A young person's user group, called Health Champions for Shropshire, was in place, and was proactive in ensuring that young people had a voice within the children's service. We saw that the group had been instrumental in the design of a young person's lounge on the children's ward.

Innovation, improvement and sustainability

- The clinical director told us how the service was developing, by creating new links in the community and with GPs, with the aim of ensuring that the services provided would best meet the needs of the local population.
- The trust was actively involved in the NHS Future Fit programme. This programme was a commitment from the trust to work with patients, the public and stakeholders, to review Shropshire's acute and county hospitals, and make recommendations for the future. Information about the programme was available on the trust's website.
- A separate parent's lounge had been provided on the children's ward. This was designated a child-free area, where parents could go to relax and make refreshments.
- Transition of services to the new centre included facilities for parents to be able to stay with their babies in the neonatal unit and with children in the oncology unit, in bedrooms which included en suite facilities.

End of life care

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

Information about the service

End of life care and palliative care services are provided throughout the Shrewsbury and Telford Hospital NHS Trust, and at the Royal Shrewsbury Hospital and the Princess Royal Hospital.

The trust's palliative care team and end of life care team provided a five day service, and were available 9am to 5pm, Monday to Friday, for both hospital sites. Weekend support was available through an on-call service from the nearby hospice. The team was made up of 4.0 nurses. These nurses were funded partly by the local hospice service. The trust had recently appointed an end of life care co-ordinator to improve the provision of end of life care. There were no palliative care doctors on staff employed by the trust; palliative support is provided by the hospice on a weekly visit basis. The trust has a part-time doctor who leads on end of life care; however, this is a voluntary role, and not part of their current contract.

One of the palliative care nurses was based at the Princess Royal Hospital. Inpatients who require palliative or end of life care were nursed on the wards throughout the hospital. Specific end of life care was provided for patients with renal illnesses, both acute and chronic, through the inpatient ward and the renal dialysis unit.

The Princess Royal Hospital had a chaplaincy service available, as well as access to local support and counselling services. There was a chapel on-site, where people could attend to pray. There was a bereavement team on-site; however, the majority of bereavement work was undertaken through the ward where the person died. The mortuary facilitated viewings for families who were bereaved. The facilities for the viewing of children and babies were based at the Princess Royal Hospital.

Prior to this inspection, we were informed by the trust that they had recognised that end of life care was not being delivered to a standard that they expected, and they recognised that it required improvement.

End of life care

Summary of findings

End of life care required improvements in all areas, except for caring and responsive, which were good. We had concerns about a number of aspects in the mortuary provision. Staffing levels of nurses and medical staff in palliative care were not sufficient. Staff were not provided with mandatory training in end of life care.

The trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. The service was not responsive, because there was no formal strategic plan for the service delivery of end of life care within the trust.

The service was not well-led. We found that there was oversight, by senior management and members of the executive team, with regards to end of life care that required improvement. We saw many examples of compassionate care delivered with respect.

Are end of life care services safe?

Requires Improvement

We found that the mortuary environment and equipment within the mortuary was inadequately maintained. The fridges where deceased patients are kept regularly malfunctioned, potentially compromising the integrity of the deceased. The storage capacity within the service was also insufficient to cope with increased demand.We also had concerns regarding the safety of staff outside the mortuary building.

Staffing levels of nurses and medical staff in palliative care were not sufficient to be safe. The staff currently working for palliative care were either partially-funded by another service, or providing their time voluntarily. The trust had not sufficiently invested in end of life care to make it a service, and therefore patients were at risk of not receiving appropriate end of life care.

Staff on the wards were not provided with mandatory end of life care training. Staff who have attended this training have usually financed it themselves. There were no incidents that related directly to end of life care that had been reported. Staff knew how to report incidents. We saw good hand hygiene practice by staff when they were caring for patients.

Incidents

- Staff told us that they were encouraged to report incidents, but could not recall any specific incidents relating to end of life care. This is not uncommon, as many incidents relating to the death of a patient are reported under the specialty where the death occurred.
- We found that incidents had been reported regarding the breakdown of the refrigerators in the mortuary. These incidents were linked to the risk register.

Cleanliness, infection control and hygiene

- We saw good practice with hand hygiene from staff when they were caring for patients. Staff were following the policies on the prevention of infection control.
- In the mortuary, we found that appropriate guidance was followed for maintaining a clean environment, and

reducing the risk of infection. The mortuary team worked hard to maintain a clean environment, given the physical condition of the existing mortuary, which had not been upgrade or refurbished for many years.
- The mortuary adopted appropriate protocols for high risk post-mortems, by restricting access, and securing the room whilst the procedure took place. This minimised the potential spread of any infectious disease.

Environment and equipment

- We checked a range of equipment, including syringe drivers and monitoring devices, and found all had been serviced and tested for electrical safety.
- Syringe drivers in use were standardised to one type of equipment, which could minimise the risk of human or training error.
- The mortuary environment had not been upgraded or refurbished in many years. As a result, there was a significant shortage of space to store the deceased. There were no current plans to upgrade the storage at the Princess Royal Hospital due to funding being spent on upgrading the Royal Shrewsbury Hospital.
- The mortuary refrigeration has become increasingly unreliable. The service has reported multiple breakdowns in the refrigeration units during the last year. If the units do not maintain the required temperature, it could result in accelerated decomposition of the deceased.
- The bariatric patient facility is in a separate building. The room contains bariatric tables, which patients are placed upon to minimise moving and handling risks.
- The floor between the mortuary and the outer building is uneven, and there was a potential risk that a table could get caught in the uneven surface. There is a risk of patients either tipping off the trolleys, or a staff member sustaining injury when moving the trolleys across the uneven surface.
- Outside the mortuary, the area is not a secure area. There is a staff entrance near the mortuary which enables staff to walk past the mortuary and in the road area near moving and reversing vehicles. This posed a risk to the pedestrians. We raised this concern with the trust management team during the inspection, who reported back to us that pedestrian access in the area had been restricted.

Medicines

- Staff told us that patients who required end of life care medicines were written up for anticipatory medicines. We examined the records of two patients receiving end of life care and found that anticipatory medication was appropriately prescribed.
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. This is medication that patients may need to make them more comfortable.

Records

- We examined the records of six patients receiving end of life care, or those with an advanced decision for end of life care in place. Records were comprehensive around the decision for end of life care. This included detailed recording of conversations between health professionals, and with family members and patients during visiting times. Written records were legible and clear to read.
- Nursing and medicines records were stored outside each bay. Medical records were stored in a medical records trolley, which was located near a nurse station, and could be secured.
- We reviewed the documentation for certification after a patient died. A medical certificate of cause of death (MCCD) enables the deceased's family to register the death. We found that the certificates had been issued within 14 days of death, and burial or cremation forms had been signed in accordance with the Births and Deaths Registration Act 1953.
- Where there had been any doubt as to the cause of death, or where the cause of death required a mandatory referral, for example, when a death may be linked to an accident (wherever it occurred) or to industrial disease, we found that the hospital appropriately referred cases to Her Majesty's Coroner.
- We found that there were robust consent arrangements in place for managing tissue removal after death. The last Human Tissue Authority (HTA) inspection concerns related to environment, and the trust was aware of those concerns. The HTA regulate organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public.

Safeguarding

- We examined the training records for the palliative care team, and found that 100% of the staff had received

training in safeguarding adults and safeguarding children. Across the medical areas we established that between 70% and 100% of staff in medical areas have received this training.
- Staff across the medical areas involved in end of life care were able to explain what constituted a safeguarding concern, and the steps required to report such concerns.

Mandatory training

- The palliative care team and mortuary team had access to all training sessions provided by the trust. The mandatory training matrix provided by the trust showed that the palliative care team had achieved 100% compliance with training, in subjects including infection control, health and safety, and moving and handling.
- End of life care training was not classified as mandatory training, and was not routinely offered to staff.
- Where staff had attended end of life care training we found that this had been funded locally through department or personal budgets. For example, we were informed that two nurses within the renal service had attended an end of life care course which had been paid for by their manager through their personal money. The nurses who attended the course paid for the transport and hotel accommodation in London themselves, to support their attendance.

Nursing staffing

- There were four palliative care nurses working at the trust, one of whom mainly worked on the Princess Royal Hospital site. Two of these nurses are 50% funded by the local hospice.
- The trust had recently employed an end of life care co-ordinator to support the delivery of end of life care. This post is funded for two years by Health Education England.
- On the renal unit, the service had a transplant sister in post. This post supported patients with cross-matching for transplantations. This post was funded by the British Kidney Association. The internal Human Resources processes within the hospital trust had decided not to fund this post at the end of the charitable funding period from December 2014, due to financial reasons. However, since the inspection we have been informed that this decision is subject to review.

Medical staffing

- There was a lack of medical staff support and input into the provision of end of life care at the trust.
- There were no palliative care doctors employed by the trust to support the provision of palliative care. The trust had an informal arrangement and a good working relationship with the local hospice to provide consultant support when required.
- The trust had an end of life care doctor, who also worked part time as a medical physician. The doctor had volunteered to lead on end of life care to improve services. The role was not part of their current contract.

Major incident awareness and training

- The mortuary staff had received training in emergency planning and resilience. The service had a current major incident plan, and were aware of what procedures to follow in the event of a major incident.
- The maximum body storage capacity in the mortuary was 45 (including temporary storage). Whilst this capacity was usually sufficient during the summer months when the death rate is generally lower, it was insufficient during the winter months, when the death rate is higher.
- There is a standard operating procedure in place for the management of the deceased when demand for spaces exceeds those available. This has consistently been reported as an issue during the winter for several years. The trust has reported near miss incidents, of having to store the deceased in a manner that is not approved by the Human Tissue Authority.
- The current capacity offers no resilience for unexpected surge in demand, such as a pandemic flu or Ebola outbreak. Therefore, the capacity issues within the mortuary mean that the service would have difficulty in coping with a moderate increase in deceased patients in the event of a major incident.

Are end of life care services effective?

Inadequate 

The trust participated in the National Care of the Dying Audit (NCDAH) 2014, and performed worse than the England average on five of the operational, and all of the clinical, key performance indicators. Local audits around end of life care were limited and still being developed.

End of life care

The trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. This tool was a care plan developed by medical and nursing staff to replace the Liverpool Care Pathway (LCP). The trust planned to roll this out once staff had been trained to use the tool appropriately.

The trust has recently re-issued the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms and renamed the process as 'ceiling of treatment to allow a natural death'. These renamed forms began to be issued two weeks prior to our inspection. We found that all forms had been completed in line with guidelines; however, the effectiveness of this process had yet to be tested through clinical audit.

We found that many of the services that supported end of life care to patients were working under considerable pressure, due to workload. Staff working on the wards felt able to contact the palliative care team for advice, but this service only operated during weekdays within office hours. This meant that people risked receiving a different level of service outside of normal office hours. However, we found that staff involved in end of life care often worked extra hours, on goodwill, to provide out-of-hours and weekend cover to support the delivery of care seven days a week.

Anticipatory medicines were being prescribed, and equipment to deliver subcutaneous medication, such as pain relief, was readily available. Medical staff were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life. However, the clinical decision model for adult patients who lack mental capacity was not always being followed. Input from dieticians and the speech and language therapy service was available.

Evidence-based care and treatment

- The trust adheres to National Institute for Health and Care Excellence (NICE) End of Life Care Quality Standard (QS13 August 2011). We viewed the trusts board papers through 2014, and plans which demonstrated that the trust had considered and agreed on how to improve the service.
- The Department of Health had recently asked all acute hospital trusts to undertake an immediate clinical review of patients receiving end of life care. This was in response to the national independent review, More Care, Less Pathway: A Review of the Liverpool Care Pathway (LCP), published in 2013. The service had only recently removed the Liverpool Care Pathway from use. This has been replaced with an 'end of life care' pathway, which has yet to be implemented.
- A new end of life care pathway plan, to replace the Liverpool Care Pathway (LCP) had yet to be launched within the trust. The director of nursing informed us that the trust did not want to implement a new plan unless it was used appropriately; the plan will be used when staff are trained and skilled in its use.
- The pathway had been developed across all health services within Shropshire. The end of life lead doctor and director of nursing referred to this as 'care without walls'. This document developed, by the trust, had been agreed throughout the community to ensure that patients have one care plan that ensures continuity in care. There was an action plan linked to the implementation of the new end of life care plan.
- The palliative care team are aware of the change, and the end of life care co-ordinator is leading the implementation of the new plan. Staff are knowledgeable about what a patient requires at the end of their life, and we observed that they were following the principles of the plan, which is not yet in use, to provide appropriate care.
- While visiting the ward areas, we reviewed six patient medical records containing 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. The trust has recently re-issued these forms as 'ceiling of treatment to allow a natural death' forms. We found that all forms had been completed in line with Resuscitation Council (UK) guidelines.
- In the medical records of the six patients, we found that clear and comprehensive records had been taken of the discussions held between staff, the patient (where appropriate), and their families. We spoke with two family members and one patient about their conversations. We found that people's accounts of conversations matched what was recorded in their records.
- The decision of end of life ceiling of treatment once made related to the patents in patient stay unless a review date was in place, as per hospital policy. We found that there was no evidence recorded to review the decision on the forms we reviewed.

End of life care

Pain relief

- Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication, such as pain relief, was readily available.
- The hospital had syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication, and may be used in any situation when the patient is unable to take oral medication. However, when we examined the equipment asset register, we found that some items did not have a specified date to show that they had been recently tested. By not regularly testing the function of a syringe driver it may place people at risk should the equipment malfunction.

Nutrition and hydration

- There was no specific dietician support for the palliative care team, and this meant that end of life nutritional support was provided by dieticians across the trust. However, we saw input from dieticians in the medical notes of patients. Nursing staff on the ward told us that they could always ask for dietetics advice.
- The trust had a speech and language therapy service, which provided support for nutritional and hydration needs where available. We observed an example of this being provided to a patient receiving end of life care.
- We spoke with three doctors across the medical wards we visited. All were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person's life; this included the option of clinically-assisted feeding.
- For the two patients we observed on end of life care during the inspection, both had not had mental capacity assessments undertaken. This meant that medical staff may not be adhering to the GMC's clinically-assisted nutrition or hydration clinical decision model for adult patients who lack mental capacity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the consent systems appropriately when patients did not have capacity to consent to care and treatment. The record of consent was documented in the care records.
- We examined the records of six patients with 'ceiling of treatment to allow a natural death' documentation, to determine if their mental capacity had been assessed prior to completing the decision not to resuscitate. In one case, the form had been completed stating that the patient did not have mental capacity; however, there was no record of mental capacity assessments being undertaken.
- We reviewed the Advanced Decisions (living wills) policy issued in November 2012. Section 6.7 of the policy says 'patients cannot refuse basic care'. This is not in accordance with a person's human rights or the Mental Capacity Act 2005, as a person can refuse basic care should they have the mental capacity and ability to do so.

Patient outcomes

- The trust had taken part in the National Care of the Dying Audit (NCDAH) 2014. Of the seven key performance organisational indicators, the trust had achieved above average on two indicators, but did not meet the other five indicators. The trust was reportedly promoting the privacy and dignity of the patient up to and after the time of death, obtaining access to specialist support, and prescribing required medicines.
- Of the 10 clinical key performance indicators in the audit, the trust did not achieve any of the required recommendations. This included communication regarding a patient's plan of care when dying, and assessment of the patients and families spiritual needs.
- Locally, we found that the service had undertaken an audit on the completion of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. The audit showed that appropriate discussions were not always being undertaken with patients and their families. The trust has re-launched the process of DNA CPR and renamed it as 'ceiling of treatment to allow a natural death'.
- The trust has yet to re-audit the implementation of this new process to determine how effective it has been. The re-audit is scheduled to be undertaken after three months of the process being in use. Clinical sessions, for the medical staff to improve their skills around having difficult conversations with families, are also scheduled to take place.

Competent staff

- We found that end of life care training, dignity in death, or palliative care training were not mandatory training subjects for staff at the trust. We found many instances where staff, who had undertaken training in these subjects, had done so in their own time, and in some cases through their own funding.

End of life care

- During the inspection, we found that the renal ward and renal dialysis unit had nominated a link staff nurse and a doctor to support the improvement of end of life care. These roles were voluntary, and were completed in addition to their current job roles.
- The palliative care team, pain management team, and mortuary staff had all had appraisals within the past year.

Multidisciplinary working

- The hospital has a palliative care team, who are part funded by the local hospice. The trust does not have a palliative care doctor; however, one is available from the hospice upon request. Whilst there was no formal service level agreement in place to establish how many hours per week they provide to support the trust, we were informed by all areas that they could access this support when required.
- Within the renal unit, the end of life doctor and link nurse provided hours to support the delivery of end of life care. The transplant sister and newly appointed psychologist were all funded through external bodies. The team provided guidance on making decisions about end of life care and treatment options, and gave specialist holistic advice and support for patients and their relatives.
- The palliative care team members attended regular multidisciplinary team meetings (MDT) for specialist teams, such as cancer services, renal and respiratory. The end of life care doctor also attended some of these meetings as part of the clinical specialty, and could strongly advocate end of life care needs.
- Patients under specialist teams did benefit from the palliative care and end of life team involvement. Whilst care, treatment and support was delivered to meet the patients' individual needs, this was predominantly through the goodwill and dedication of staff, as well as through external funding to support posts delivering end of life care.
- The multidisciplinary team available worked well together to ensure that patients care and treatment was planned and co-ordinated. We spoke with two families who were positive about the care they received and the support they were given.
- There were effective working relationships with local hospices to co-ordinate people's end of life care where the hospice was their preferred place to die. Equally, if a person preferred to die at home, arrangements could be made to facilitate this. The use of the palliative care team ensured continuity of care when working with community teams.

Seven-day services

- The palliative care service was only available Monday to Friday, within working hours. Out-of-hours support was provided at the weekends from the local hospice, although no formal agreement had been established.
- We found that staff providing end of life care, including the end of life care team, palliative care team, link nurses, and medical staff with a voluntary role as end of life medical leads, often worked to provide out-of-hours and weekend cover, to support the delivery of care seven days a week. This was provided as goodwill to deliver a service to the patients.

Are end of life care services caring?

Good

Staff at the Princess Royal Hospital provided very compassionate care to patients from the time a terminal diagnosis was given, until the time of their death. There was good recognition of the importance of family and friends as life ended.

We observed outstanding examples of end of life care on the renal dialysis unit, when supporting patients to make decisions regarding their wishes. Staff shared their recent experiences of patients receiving dialysis, and holding birthday parties and Christmas parties to celebrate events. Staff also told us that they were often asked by families to attend the funerals of patients. The dedication and passion to provide a caring service was observed throughout the visit. All patients and relatives we spoke with on the renal ward and renal dialysis unit spoke highly about the level of compassion and care displayed by these teams.

Locally, the teams within the wards visited, which included respiratory, care of the elderly, renal and the renal dialysis unit staff, spoke highly of the care offered by the palliative care team and the end of life care link staff, including the lead consultant for end of life care. Many of the roles that support the delivery of end of life or palliative care were

End of life care

developed through staff's passion to deliver good care at the end of a person's life. Staff worked above and beyond the call of duty to try and support patients and their families at difficult times.

Compassionate care

- Throughout our inspection we witnessed patients with a terminal diagnosis, and those approaching or who were at the end of life, being treated with compassion, dignity and respect. We spoke with three patients and two family members during our inspection, specifically about their experience of end of life care. All told us that they were cared for exceptionally well.
- Staff on the renal unit provided us with examples of when they had been invited to the birthday celebrations and funerals of patients. Staff were engaged in care at a level that meant that families felt supported by the staff when a patient and their family went through difficult times.
- We spoke with three patients on the renal unit and one family; all were highly complimentary about the level of care and compassion that staff within the renal service displayed towards them. Comments included "they are just so supportive" and "they are so wonderful".
- The chaplain told us that they were able to assist the nursing staff to ensure that care and treatment was provided to patients with due regard to their religion. The wards we visited, which included respiratory, care of the elderly, renal and the renal dialysis unit, told us that they received regular input from the chaplaincy team.

Patient understanding and involvement

- The NHS inpatient survey results showed that the trust was in line with the England average on questions asked about the care and involvement of patients and their families during treatment in hospital.
- The palliative care team worked with the clinical teams to arrange, where possible, for the patient to die in their preferred place of death. During the inspection, we observed that a patient's care on the renal ward had been discussed during a multidisciplinary meeting. Consideration to the patient's preferences on place of death was given.
- In the renal service each patient with end-stage renal disease (ESRD), which is when the kidneys are no longer able to work at a level needed for day-to-day life, has a named nurse. The named nurses provide a personable relationship with the patient to talk about their condition as it progresses.
- All patients receiving end of life care that we spoke with, knew who their named nurse was within the renal service. The two patients who were nearing the end of life knew who their palliative care named nurse and their doctors were. The relatives of the two patients we spoke with also knew who their relative's named nurse and doctors were.

Emotional support

- Chaplaincy support was available 24 hours a day, via an on-call system. The ordained chaplains were supported in their work by chaplaincy volunteers. The chaplaincy service covered the two hospital sites, and there were only three chaplains available for on-call. As a result, the service was stretched.
- Within the renal dialysis unit, the service had recently secured financial support from an external source to fund the role of a clinical psychologist to support the emotional needs of patients. This role was seen as a critical support to patients classed as 'end stage' in their treatment.
- Support was available from the mortuary and the bereavement team, to support people who wished to view deceased relatives. The mortuary staff explained to us how they would support people and make the difficult experience as comfortable as they could, and offer support to meet individual patient needs.
- For women who were bereaved following the loss of children, specialist support was available through the bereavement midwife.

Are end of life care services responsive?

Good

The end of life care and palliative care teams supported the provision of rapid discharge, and rates of discharge within 24 hours were in line with the England average. For patients who were deemed to be nearing the end of their life, the normal visiting times were waived when relatives visited the hospital, and discounted parking fees were also available.

Complaints were being recognised and lessons were being learnt from the concerns. Relatives were being invited to share their experience to learn and improve the delivery of end of life care.

End of life care

Service planning and delivery to meet the needs of local people

- The trust had a policy in place regarding visiting times for visitors in ward and department areas. This policy was usually enforced by the person in charge of the area. We found that for patients who were deemed to be nearing the end of their life, the normal visiting times were waived when relatives visited the hospital, and that discounted parking fees were also available.

Access and flow

- The pathway was being supported by the end of life care team and delivered with support from the palliative team, to improve the care provided to people at their place of death, and our observations supported that rapid discharge arrangements were improving.
- The mortuary service had little resilience to avoid the storage of deceased patients in un-refrigerated areas of the mortuary but had contracts in place with local undertakers for additional storage space.

Meeting people's individual needs

- Within the renal unit, a member of the team had developed a supportive document called 'my wishes'. This document supported people to make decisions regarding their care and their plans when they were at the 'end stage' of their condition. Staff shared with us examples of how this document would benefit the empowerment of people, to make decisions and arrangements at the early stage of their condition, and encourage them to seek support. This is a project that the renal team hoped would be taken trust-wide in relation to all 'end stage' conditions.
- The discharge team and the palliative care team detailed their processes for discharging patients within 24 hours. The trust was in line with the England average on meeting the rapid discharge requirements.
- The trust was compiling its data and evidence of patients who were able to die in their preferred location. Whilst no actual figures were available at the time of inspection, the director of nursing recognised that improvements around the delivery of patients' needs were required.
- Services for the recently bereaved were provided. The multi-faith chapel was designed for people holding a range of different beliefs, and translation services were available 24 hours a day through a telephone service.
- When patients wanted to visit the mortuary to view a deceased relative, there was limited parking for relatives. The mortuary viewing room for children was recently built to coincide with the opening of the new women and children's unit. It was a separate area to the one for adults. The room was refrigerated and time limited for people to view their children, due to the room temperature.
- There was a selection of patient information materials available to support patients and their families in understanding what to expect at the end of life, and when a terminal diagnosis is given. We saw that these were available around the hospital.

Learning from complaints and concerns

- Complaints were recognised and lessons were learnt from the concerns. The lead doctor and director of nursing reviewed and responded to every concern about end of life care.
- The trust had received five complaints in the past few months in relation to end of life care.
- Patients or relatives who had raised concerns about end of life care were invited in by the director of nursing to attend the trust board meetings to share their experience. We viewed the trust board minutes, and identified three examples over the last six months where relatives had attended and shared their experience.

Are end of life care services well-led?

Requires Improvement

Locally, those providing end of life care within departments led the provision of this well. The clinical lead demonstrated good leadership, and clearly wanted to drive improvement around end of life care.

We found that there was limited oversight, by senior management and members of the executive team, with regards to end of life care, and this required improvement; but it was developing as the trust had recently recognised end of life care as a key area for development. The director of nursing was the executive director for end of life care. She was able to demonstrate that she understood the enormity of the improvements required around end of life care.

End of life care

Vision and strategy for this service

- There was no clear vision or strategy for the provision of end of life care. Staff providing end of life care were aware that there were plans being developed to improve the trust's end of life care pathway, but they were unclear when it would be launched.
- Locally, staff understood what their contribution was to providing care to a person at the end of their life. Each service had its own strategy for this. In the mortuary, there were clear procedures for end of life care. In the renal service, the team had developed their own strategy to support end of life needs which were specific to end stage patients.
- The transplant nurse role within the renal service had supported a vision for the service to improve patient outcomes and chances to receive a transplant. The funding for this role was scheduled to run out in December 2014. We found that the role had been declined for funding through the human resources vacancy control group. Therefore, this role will no longer be available after December, which will have a significantly negative impact on patients in the renal service. At the time of writing this report, we have been informed that the decision not to fund the post is subject to review.
- The trust does not have a functioning organ transplant meeting. This is an area which has been recognised by the director of nursing as needing to be re-launched.
- The trust has recognised that mortuary services require improvement, and funding has been approved to improve the mortuary environment to provide a sustainable service.
- Staff told us that any improvement in service provision had to include funding for extra staff, because they had no further capacity within the current service workforce.

Governance, risk management and quality measurement

- The director of nursing and end of life care lead doctor were undertaking the quality measurement of end of life care, and recognised what needed improvement. At the time of inspection, there was no definitive risk management or quality measurement plan with timeframes for improvement in place. However, both understood what work was required.

Leadership of service

- The director of nursing has recently taken up the role of executive lead for end of life care. There was no executive or non-executive leadership for the service prior to this.
- Locally, staff told us that they felt supported by their immediate managers; however, they did not always feel supported by the senior management team. Staff also felt a lack of engagement from the executive team around end of life care.
- Within the renal service the team had good leadership, understanding, and knowledge with regard to end of life care. The service had internally self-appointed a link nurse lead for end of life care, and a renal consultant also took the lead as a named doctor for end of life care in renal.
- The end of life care doctor also worked as a consultant within medical specialities. The hours provided to end of life care were provided out of goodwill on a voluntary basis. The lead consultant demonstrated good leadership, passion and dedication to the improvement of end of life care; however, their role lacked the required support from the trust.
- At the time of our inspection, there was no non-executive director with responsibility for end of life care. This is a recommendation from Norman Lamb after publication of the review of the Liverpool Care Pathway in his letter to NHS trust chairs and chief executives in July 2013.
- There is currently no palliative care consultant employed by the trust. The service utilises an informal arrangement with the local hospice; however, this is informal and there is no service level agreement in place.
- The team providing end of life care is limited. Of those providing an end of life care service, the trust contributes little to these roles financially. The four palliative care nurses were part funded by the local hospice. The end of life co-ordinator post was funded by Health Education England. The transplant sister and clinical psychologist in the renal service were funded by the British Kidney Association. The reliance on charitable and voluntary funding means that the provision of support for end of life care for this trust is not sustainable.

End of life care

Culture within the service

- We observed examples of staff members who worked as visible and approachable leaders for end of life care. We also observed examples of a staff member who worked below their pay grade and volunteered to work at the lower pay grade to ensure care was delivered to patients. This showed dedication to the delivery of improved patient care; however, it did not support staff well-being.
- Locally, the passion and dedication towards delivering good care at the end of a patient's life was clear to see throughout the inspection. The palliative care and end of life team dedicated a lot of hours to delivering the best service possible within their available resources. However, much of this was provided on the goodwill of staff, and there was limited input and oversight from the trust executive management and senior management team.

Public and staff engagement

- Staff shared examples of escalating concerns to senior management and members of the executive team over the past two years, but had received little or no support or response. Issues raised included the environment and capacity within the mortuary, and the specialist staff support in the palliative, end of life and renal service. However, we were told that staff engagement had improved in recent months.
- Relatives of patients had been invited into the trust to share their experience openly to improve the service.
- The service promoted the completion of the national bereavement survey, and was aiming to improve their response rates from the public.

Innovation, improvement and sustainability

- Locally, we saw numerous examples of innovative practice, particularly in the renal service, with the functions of the transplant sister and the end of life care link nurse. There was also a consistent drive to secure funding from external sources to improve their service for patients.
- On the renal dialysis unit and ward, the service secured a two year funding arrangement for a transplant sister to support renal transplantation. The role supports the cross-matching of patients to receive transplant through live and deceased people. From April 2013 to April 2014 the number of patients who received a transplant increased from 12 to 17. This included six new live donor transplants.
- We found that the team have also established, through promotion of services, another nine people willing to be consulted and matched to be able to provide a kidney as a living transplant organ donor. This work is significantly improving the outcomes for patients receiving dialysis.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

There are two main outpatient facilities, which are based at the Royal Shrewsbury Hospital and the Princess Royal Hospital Telford. The two locations have local management systems, which are overseen by senior managers at trust level. This report concentrates on our findings at the Princess Royal Hospital Telford.

During the period April 2013 to April 2014, the Princess Royal Hospital conducted 238,848 outpatient appointments, of which over 83,500 were for first appointments. On the day of our inspection, we were able to visit a number of clinics providing specialist services; these included diabetes, physiotherapy gym, audiology, fracture clinic, cardiology, colo-rectal, ear nose & throat (ENT) and ophthalmology. We also visited X-ray and scanning services, and support and administration departments.

We observed how staff interacted with patients, their families and carers. We spoke with 35 staff working in the clinics, and with 18 patients or family members about their care and treatment.

Summary of findings

Overall, we rated this service as good. During the inspection we did identify a small number of areas where the trust could improve. The trust had prioritised statutory training; however, refresher mandatory training had not been completed by the majority of staff. Staffing levels were in line with national guidance.

We saw good practice and effective compassionate care. Patients were very complimentary about all the staff they had come into contact with. We found that clinics followed national guidance and good practice relative to their individual specialities.

Diagnostic services at the Princess Royal Hospital did not have access to a screening room which was suitable for paediatric services. We saw how a patient who might have benefited from the use of appropriate screening equipment had to undergo an alternative treatment. Whilst the alternative had been safe and appropriate, staff told us that the method used would not have been their first choice had they had an option. Services were managed well at a local level.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found issues with the level of mandatory training for staff in both outpatients and diagnostic imaging. Staff were able to demonstrate a good understanding of the subjects; all staff had received training previously either on induction or during previous years. However; this did mean that the trust could not be confident that staff were aware of the most recent practice and guidance.

The clinics and areas we visited were visibly clean and tidy; patients told us that they had always found them to be clean on previous visits. Staffing and skill mix were appropriate to the services provided, staff had received specific training relative to their speciality. We saw how staff shared learning from analysis of incidents and complaints to prevent mistakes reoccurring.

Equipment was maintained to ensure that it was available when required, and that it operated safely. There was evidence of equipment, which was reaching the end of its useful life, being replaced. There were effective systems to safeguard children and vulnerable adults from abuse. Staff understood how to recognise the different forms of abuse and how to make a safeguarding referral if they had concerns.

Incidents

- The trust used the Datix reporting system to record incidents and issues of concern. Staff at all levels of the organisation were aware of how to use the Datix system, and many were able to explain when they had used the system to report incidents. Some staff told us that they did not always receive feedback about incidents; however, they described how more serious incidents were responded to, which gave them confidence in the system as a whole. During a focus group with healthcare workers and student nurses, which included staff from a number of areas including outpatient and diagnostic services, they told us that they understood Datix and found it easy to use.
- In the period April 2013 to April 2014, the trust reported a total of nine serious incidents in relation to outpatient and diagnostic services. The Princess Royal Hospital accounted for one of the serious incidents.
- We saw that incidents had been investigated, and root cause analysis had been completed to identify causes for the incidents. Patients and their families had been involved and informed, as had stakeholders and commissioning groups.
- Learning from incidents and complaints was shared within teams; we saw evidence in minutes from team meetings of how incidents and complaints formed a regular agenda item, and were discussed openly to ensure learning was shared.
- No ‘never events’ had been recorded by outpatient and diagnostic imaging services. NHS England define never events as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'.

Cleanliness, infection control and hygiene

- The trust had effective infection control procedures within the outpatients and diagnostic screen services. We observed staff using personal protective equipment (PPE) in the form of gloves and aprons. We saw that supplies of PPE were available in treatment rooms.
- Patients told us that they had seen staff wash their hands before and after examinations.
- Public waiting areas were clean and tidy. Patients told us that they had always found the hospital to be clean and had no concerns about attending. We were told by staff that the trust had brought in external cleaners prior to our inspection. However, patients told us that they had not noticed any difference since their last visit. They had always found the outpatients and imaging areas to be clean.
- Staff we spoke with had a good understanding of the principles of infection prevention and control, and they were able to describe the training they had received and how they comply with good practice.
- We saw hand washing guides adjacent to wash basins to remind both the public and staff of the importance of hand hygiene.
- Hand sanitising gel was located strategically around the department, and at entrances and exits, with polite notices to remind people to use the gel.

Environment and equipment

- Public areas inside outpatients and diagnostic screening areas were well maintained. The buildings provide a bright, relaxed atmosphere. Seating areas were well lit and comfortable. Patients told us that they found the environment “functional but uninspiring”.

- The trust had a responsive maintenance team. Staff told us that issues were dealt with quickly, and they did not have any problems obtaining replacement equipment if it were needed.
- Diagnostic and screening equipment was maintained under contract, with regular services undertaken. The superintendent radiographer explained that they worked closely with their counterpart in Shrewsbury, and the services at the two sites complemented each other.

Records

- All of the staff that we spoke with, including administrators, clerks, secretaries, nurses and clinicians, told us that the trust had an issue with the availability of patient health records at clinics.
- Staff told us that health records often did not arrive in time for clinics.
- Issues regarding availability of health records had been placed on the trust risk register for the outpatients department. The trust had implemented a number of actions to address the situation, including appointing a manager to collate and map the location of missing record reports, and feed the information back to senior managers, and to individual departments or staff, where they were found to be contributing to the problem.
- Temporary records were created where original sets could not be located in time for clinics; temporary records were prepared by the records staff. They were produced from clinic letters and other information held electronically by the trust, and enabled patients to be seen and treated at the discretion of the doctor. The temporary notes were later married up to the original notes when they were found. This meant that the trust had a system in place to ensure that wherever possible, people received appropriate care and treatment if their medical notes were not readily available.
- Health records were updated by doctors or specialist nurses at the time that they saw patients; this ensured that important information was recorded at the time. Patients told us that their doctors appeared to have a good understanding of their case, and knew why they were attending clinic; they told us that this gave them confidence that staff were interested in their health and welfare.
- We spoke with a registrar, who told us that they had sufficient time to review patient notes prior to patients being called into consultation. They described how they dedicated additional time to reading the records of new patients, to ensure that they had a full understanding of their needs; they told us that they were supported by their consultant, and if they had any issues, they could approach them at any time. All cases were discussed with the consultant at the end of each clinic to ensure safe and accurate diagnosis and treatment had been provided.
- Staff also told us that clinic letters had caused problems for patients at both Telford and Shrewsbury hospitals. A number of letters had been posted to patients asking them to attend clinics, but the letters had been posted after the date of the clinics in question. This meant that patients missed appointments, and then had to wait for new appointments to be given, during which time their health could deteriorate. We did speak with two patients who told us that earlier in the year, they had received appointment letters after the date of their appointments; they told us that they had not personally experienced any deterioration in their health, and that recent letters had been received on time.
- We saw that hospital volunteers transported health records between departments. We also saw volunteers holding individual patient records and calling for patients when escorting them to clinics. We were told that all volunteers had undergone security checks, and that they did not access the records; they simply called patients according to the name on the folders; this meant that people's privacy was protected.

Safeguarding

- Staff in the outpatients and diagnostic screening services had a good understanding of safeguarding issues; they were able to describe the forms of abuse which people may suffer, and how to escalate any issues they had.
- All staff had received safeguarding training appropriate to their roles. Staff we spoke with were aware of how to report matters.
- Staff were supported by the trust safeguarding team, with a named nurse and named doctor for staff to approach for advice or guidance.

Mandatory training

- In addition to specialist training which individual staff or teams undertake, all staff were required to attend statutory and mandatory training. Statutory training should be completed to ensure that staff know how to keep each other, patients and visitors safe.

Outpatients and diagnostic imaging

- Mandatory training is typically undertaken to provide assurance that local policies governing key corporate and risk activities were understood and followed by employees.
- Statutory training figures for the Princess Royal Hospital outpatients and diagnostic screening services departments averaged 83.33%, against a trust target of 75%.
- Mandatory training figures, against a trust target of 75%, were only 11.66%.
- Staff we spoke with knew about the areas covered by the mandatory training, because they had covered the topics previously, or during their induction. However, in these circumstances, the trust cannot be satisfied that staff have the latest information and advice, or have maintained their knowledge base to an acceptable level when training is so low.
- Local managers told us that there had been a combination of factors which had impacted on training; these included lack of trainers, lack of courses, and availability of staff to release to attend training. Alternatives were being considered, and some training had been moved to computer-based training; however, availability of computer terminals had prevented this being expanded.

Management of deteriorating patients

- Patients with identified vulnerabilities were dealt with in accordance with their needs. We saw how practice had been changed as a result of enquiries into an incident where a patient had fallen from a chair.
- Patients were encouraged to bring family or friends with them who could support them. Where patients attended on their own, staff sat them in areas where they could observe them and react with any assistance which was required.

Nursing staffing

- Staffing of clinics within the outpatients departments was within national guidelines set by the Department of Health. Absences, both planned and unexpected, were covered by staff from the departments, or in some cases by bank staff employed by the trust, but with the skills required for the departments concerned. Staff we spoke with were proud that they had been able to provide continuity for their patients from within their own teams.
- Turnover of healthcare workers and nursing staff within outpatient departments was in line with the trust average at 8.15%. Clinic managers told us that most staff move on through personal development.
- We were given examples of how staff numbers were calculated to accommodate the type of clinic, and needs of patients who were expected to attend.
- Patients with special needs were usually identified at the time of referral and, if required, additional staff could be called in. Managers described how patients with carers were supported and how carers were encouraged and assisted to provide support during clinic or imaging appointments.

Medical staffing

- Imaging departments provided service on a seven-day basis, including out-of-hours cover. Consultant cover out of hours was provided on a rota basis, and we were shown how consultants could access imaging results remotely, and provide advice or guidance to staff on-site. Where required, consultants would attend in person.
- The majority of outpatient services were provided on weekdays, during core hours of 8am to 8pm. Seven-day working was being proposed, and the trust were in consultation with staff and unions regarding changes to working practices.

Major incident awareness and training

- Staff at all levels were aware that the trust had major incident and business continuity plans. Junior staff stated that they understood they would be given a specific role, dependent on the incident, and this would be dictated by their supervisor or manager. Clinic managers and more senior staff referred to actions within the plans which they were required to undertake.
- Staff were aware of how to access incident plans on the trust intranet.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw that care was based on recognised pathways of care, and in accordance with national guidance. Staffing levels and skill mix were in line with national guidance. Absences were largely filled from within teams, rather than

using agency staff; this meant that staff were familiar with the environment, and how services were run, providing continuity for patients. Local audits were completed and data shared with the trust, which ensured that standards were monitored at an appropriate level.

Clinics followed NICE and recognised national guidance in their specialities. Staff understood the pathways of care and demonstrated that they understood how to recognise when people were not progressing in line with expected outcomes. Senior staff described how they protected the rights of people who could not make decisions for themselves, either through illness, or because of their condition, and how best interest decisions were made in accordance with the Mental Capacity Act 2005.

Evidence-based care and treatment

- We found that clinic specialities worked in accordance with good practice and national guidelines. Staff at all levels understood their role, and healthcare and nursing staff told us how they were familiar with expected outcomes for treatment. They explained how they would highlight any issues they saw, or any comments patients might make regarding their health, to senior staff, so that clinicians or specialist nurses could be made aware.
- We saw that audits had been completed on various aspects of the service, to ensure that staff understood and followed guidance. Patient satisfaction cards had been used to demonstrate to staff areas which had been commented on, such as staff attitude, resulting in staff awareness increasing, and complaints reduced.
- Staff numbers and skill mix reflected guidance from the Department of Health and Royal College of Nursing. Almost all of the outpatient departments we visited told us that they filled absences from within their own teams; they did not use agency staff, although some did make use of bank staff, who were employed by the trust and known to have the skills or experience required for their department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked senior staff in both outpatients and imaging services how they catered for patients with special needs, such as learning disabilities, or people with mental health issues. They were able to describe the process they would use to ensure that consent to care and treatment had been properly assessed and documented, to ensure that best interest decisions had been made. The processes they described mirrored the requirements of the Mental Capacity Act 2005, which meant that patients and their families could be confident that their rights would be protected if they needed to attend the hospital.
- Staff told us how carers or relatives who attended clinics with patients were encouraged to remain and assist wherever this was possible. They told us that this enabled the patient to have a familiar person present, who they trusted, and who could reassure and support them.

Patient outcomes

- Outpatient and diagnostic imaging services participated in national audits at trust-level, including diagnostic imaging data set analysis (DID), and the direct access audiology referral to treatment pathway.
- July 2014 figures for date of referral to date of test in diagnostic imaging in the areas of computerised axial tomography (CAT), diagnostic ultrasound, magnetic resonance imaging (MRI), nuclear medicine, and plain radiography (X-ray) showed that the trust performed better than the average of all English hospitals. However, during the same period, the trust performance was below the national average for fluoroscopy and single photon emission computerised tomography.
- The (DID) statistics show that overall trust performance is in line with the national average in most areas.The evidence presented to us demonstrates that whilst statistically the trust do not appear to complete reports as quickly as the national average, the overall referral to report times exceed the average due to the shorter referral to test time; the exceptions being fluoroscopy and single photon emission computerised tomography (SPECT).
- NHS England statistics for direct access to audiology, referral to treatment times for both completed pathways and current patients during the month of August 2014, showed that the trust met 100% of the targets, which was above the national average.
- A parent told us of the treatment that their child had received in orthodontics; they said “the staff were brilliant and the results were astonishing”.

Competent staff

- Staff understood their role, felt supported and had regular supervision. Whilst mandatory training attendance figures were low, staff were able to describe

the content of training, either from memory of their induction, or from previous courses; however, they were unable to say if guidance and best practice had changed since they had last been trained. This meant that staff could not be confident that they were using best practice in all areas of their work and interaction with patients.

- Staff told us that they had regular supervision and staff appraisals where they were able to raise issues or outline their aspirations. We saw evidence in records which confirmed what they told us. However, a number of staff said that it was difficult to progress, as they had no time to study; they told us that all their time was dedicated to looking after patients, and whilst they felt staffing levels were adequate, there was no down time in which to expand their knowledge.
- We saw from minutes of meetings that complaints and serious incidents were discussed during team meetings and handover sessions, with learning shared across teams and disciplines. This meant that staff had the opportunity to increase their knowledge and skills, and identify areas for improvement.
- Staff, where applicable, had been able to maintain their professional registration. Some nursing staff said that they had needed to work at home to provide evidence for their registration, as there was no free time at work. They said that staff numbers were sufficient to provide a good level of service on a day-to-day basis, but they felt they did not have time to develop additional skills.

Multidisciplinary working

- Patients told us how they had been referred to other services, both at the hospital and at community-based clinics, to complement their treatment; these included physiotherapy services, dieticians, and speech and language therapists.
- We were given examples of where joint clinics were provided; the diabetic service having dieticians working in clinics alongside the consultants.
- Patients described how the hospital had communicated with their GP, or with community clinics, and updates on their care or treatment had been known by the GP or clinic staff when they had attended appointments with them.
- We observed practice in the physiotherapy gym in relation to two patients, and other patients described having been referred to physiotherapy, occupational therapy, and speech and language therapists, as part of their ongoing care.

Seven-day services

- Imaging services worked seven days a week, and provided services to both inpatient wards and outpatient clinics.
- Outpatient clinics worked five days a week, with some Saturday clinics. They were in the process of consulting with staff and trades unions regarding the implications of moving to a seven-day service. Staff told us that they tried to be flexible, and ran clinics until 8pm to enable people who worked, or who needed assistance from relatives who worked, to access services.
- Breast clinic staff described how they had been informed of plans to increase staffing levels over the coming months to enable them to provide cover over seven days.

Access to information

- We saw that the trust made good use of information technology (IT). Imaging services were able to input results from scans and X-rays, such that consultants at other sites, or from their home if on-call, could access the images, and provide remote advice or guidance to staff.
- Patient health records could not always be located in time for clinic appointments; however, in the majority of cases, temporary sets were compiled by records staff to enable doctors and specialist nurses to have sufficient information to provide appropriate care, treatment and support. One doctor we spoke with explained how they had access to all clinic letters regarding a patient, through the computer terminals in the consulting rooms. They told us that it would have to be a very complex case to warrant an appointment being cancelled; they said they were not aware of any appointments being cancelled due to the notes not being available.
- Patient safety alerts were circulated to health care providers by the NHS, to alert staff to risks which have been identified. We were told that patient safety alerts were shared with staff during team and department meetings. Staff were unable to recall any recent alerts, but one member of staff referred to advice which had

been circulated earlier in the year regarding caring for patients during a heatwave. This showed that staff had access to important information, which could affect patients.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic services were caring. Patients we spoke with could not speak highly enough of the staff who had dealt with them. Staff in all the areas we visited told us that they were proud of how they dealt with patients in their care. We observed how staff interacted with patients, and their families and carers. We saw that compassionate, friendly and professional care was provided.

We observed many instances of staff approaching patients, and offering assistance, rather than waiting to be asked. Patients told us that staff had taken time to explain their treatment to them. They had been able to ask questions without feeling embarrassed, and staff had responded in a way in which they were able to understand. We observed and were told about the sensitive way in which staff had dealt with patients and their relatives. We saw how relatives who were waiting for patients, were updated as to their progress, and how long they might be expected to wait.

Compassionate care

- We observed how staff interacted with patients during their visit to the various services; we saw that staff were friendly and welcoming to patients and their families. We saw staff as they spoke with elderly people, and saw that they allowed people time to consider what they had been asked and to provide a response.
- Patients told us that the nursing and health care assistants could not be faulted. Patients found staff to be pleasant, friendly, knowledgeable and caring.
- We spoke with a disabled patient who had attended an appointment and found that it had been cancelled. The patient described how the staff had been supportive and appeared genuinely concerned. They told us “the staff tried to see if I could be seen, they were really nice, they did what they could”. We made enquiries about the cancellation with staff. We found that the cancellation had not been caused by the hospital. Staff knew of the patient and referred to them by their first name during the conversation, and described how they had made enquiries to see if appropriate staff might be available to prevent the patient having a wasted journey.

Patient understanding and involvement

- Patients told us that they had been fully involved in discussions about their care and the options which were available to them. They told us that they felt empowered to make decisions and did not feel that they were pressured into taking a particular course.
- Patients told us how staff had allowed them time to consider their responses to questions, and how they had been encouraged to ask questions if they were unsure about what had been discussed.
- When we spoke with a registrar in the diabetes clinic, they explained how they gave patients information about their condition and how it could affect them. They explained how having a relative or friend present often helped people to understand the issues and options available to them.
- We saw how patients had been provided with information about their condition, or any after care which was required. Sources of additional information and contact numbers were included.
- We spoke with a patient and their relative who had attended for a blood test. The patient had very little English, and their relative had explained the procedures on behalf of the staff. They told us that staff had been very patient, and respectful and understanding

Emotional support

- Patients and family members were very complimentary about the way in which doctors and senior nursing staff had explained their condition, and the impact it might have on their lives. They told us that they had been given clear information in a way in which they could understand. Patients said that they had been given time to consider the information and to discuss any issues they had.
- Staff in all the areas we visited told us that they were proud of how they dealt with patients and their families.
- One relative described how staff in X-ray had needed to remove a ring from the hand of their relative before they could complete the procedure; they described the actions and demeanour of the member of staff as ‘very sensitive’.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

Outpatients and diagnostic services at the Princess Royal Hospital were responsive to people's needs. We did have concerns about the lack of a screening room suitable for children and young people, as the trust had moved all of its women and children's services to this site. However, alternative methods were available which enabled people to receive appropriate care, even though the process would not have been the first choice of staff had they had access to an appropriate screening room.

Patients told us that they had been given choices in relation to where and how they were treated. The trust complaints system provided effective analysis and feedback to the departments, which enabled staff to learn and prevent similar issues arising. Complaints were dealt with in a timely way, and complainants were kept informed of the progress of any enquiries and the outcome of complaints. Information on complaints and incidents were shared with commissioning bodies.

Translation services were available to assist people who needed them, although staff explained that they were rarely needed, as carers or family members often accompanied patients and acted as go-betweens with the patients consent.

Service planning and delivery to meet the needs of local people

- Outpatient clinics were planned six weeks in advance; letters were sent out to patients confirming appointment times and identifying the clinic concerned. Text messages were sent a few days before the appointment date to remind people of their appointment.
- After their initial referral, dependent on the type of clinic involved, their position within the treatment pathway, and their personal circumstances, patients could elect to use community-based clinics, or either of the main outpatient departments.
- Prior to and during the inspection we received information regarding appointment letters being sent to patients after the stated date of the appointment. The trust were aware of this, and their enquiries had identified an issue with how and where appointment letters were printed. This issue had been addressed, and managers were confident that new systems would prevent further incidents.
- Administration staff told us that if a patient did not attend an appointment, they would try to contact them to see what the reason was for failing to attend, and they would offer alternative dates to encourage patients to re-engage with the service.
- Evening and weekend clinics were planned to enable people who had difficulty attending clinics during working hours.

Access and flow

- Referral times for outpatient and imaging services were in line with national guidelines.
- We saw that outpatient appointments were sent out as block appointments, which meant that morning or afternoon appointments all had the same start time. We asked the hospital for information regarding how long people had needed wait after attending the clinics before they were actually seen. We were told that whilst the arrival time of patients was recorded when they booked in, the trust had no way of monitoring how long people were in the departments before being seen. This meant that some patients had long waits before being seen.
- Most patients we spoke with told us that they had only had to wait for short periods of time of between 15 and 30 minutes. However, we did speak with some patients who had been waiting for up to an hour.
- Patients told us that they expected to have to wait at the hospital, and they planned their day accordingly, including allowing time for travel, and in some cases time to find parking, in addition to waiting to be seen. Most patients said they had been seen sooner than they had expected to be, which resulted in them feeling happy with the service provided.

Meeting people's individual needs

- Women and children's services for the trust had been centralised at the Princess Royal Hospital at the end of September 2014. When we spoke with staff in diagnostic imaging at the Princess Royal Hospital we learnt that there was as yet no screening room suitable for screening children and young people. The screening room at the hospital operated at too high a dosage to be considered safe for children and young people.

- On the day of the inspection, a child had needed a screening procedure, but due to the unavailability of equipment had had to undergo an alternative procedure. We were satisfied that the procedure used was safe and had been correctly authorised, administered and supervised. However, staff informed us that it would not have been the preferred method of diagnosis had the appropriate equipment been available.
- Staff explained that patients with complex needs were usually accompanied by carers or family members. Access was available for patients in wheelchairs, or those who used walking aids. Staff described how they encouraged and supported carers to enable them to remain with the patient, so that they had a familiar presence and, where required, assistance with communication.
- We saw that patient's relatives were welcomed into consultation rooms if the patient was happy for them to be present. Patients we spoke with described being able to speak openly with doctors and their relatives; and their relatives had been able to take an active part in the discussions about options for treatment and associated issues. This was also reflected in the comments of doctors and nurses we spoke with.
- The outpatients and diagnostic imaging services did not have a dedicated translation service. Staff explained that very few patients attended who were unable to speak or understand what was being said. Telephone translation services were available.
- Staff told us that they treat all patients the same, including those with special needs or learning disabilities. They said that they would take additional care to ensure that the person understood everything that was happening, and that they had provided consent, or that best interest decisions had been completed correctly to protect their rights. Most people with severe difficulties were accompanied by carers or family members, who were able to understand their needs and help them with any anxiety or decisions.
- Staff told us that people with dementia were a regular part of the service; they were almost always accompanied by family or carers, and very often well able to understand and consent to treatment. Family members told us that doctors and nurses had included them in discussions about health and medication requirements.

Learning from complaints and concerns

- The service had a complaints policy, and information and support on how to complain was available through the trust Patient Advice and Liaison Service (PALs). We saw information leaflets in various locations during our inspection, and the trust had a comprehensive section on complaints on their website, which included information on what to expect if you complain, and advocacy services to assist people.
- We saw how complaints had been analysed and the learning shared amongst teams. Regular meetings were held, where complaints and incidents were discussed as part of the standing agenda.
- Diagnostic imaging had created dedicated feedback forms which were available for patients to complete, or to take away and provide their response later. These had been used to feedback to staff areas highlighted by patients, to enable them to improve the service provided.
- Prior to our inspection visit we had received information from individuals and patient groups that they had been sent appointment letters for clinics which had already taken place. Other patients told us that they had attended appointments only to be turned away when they arrived, as clinics had been cancelled. We found that the trust had responded to the complaints and identified the issue. The system for printing and checking letters had been changed to prevent further incidents.

Are outpatient and diagnostic imaging services well-led?

Good

Outpatient and diagnostic services were well-led. Diagnostic imaging formed part of the trust's support service care group. Outpatient departments formed part of the trust's scheduled care group, which was led by the assistant chief operating officer, supported by the group head of nursing, and group medical director.

We found that managers and clinic leads were liked and respected by their staff; they understood their role and the importance of their department or unit to the trust. Systems were in place to enable managers to monitor and influence the work in their domain. Regular meetings took

place between senior managers and department leads. Issues from teams were highlighted, and information and feedback from senior managers and board level decisions were cascaded down.

Trust policies and procedures were understood by staff and followed; however, issues with training were not always addressed or escalated sufficiently to ensure that staff received the most recent training in all areas. We saw evidence of good communication and liaison between managers at different sites regarding their services, which ensured good practice or issues were shared.

Vision and strategy for this service

- Staff we spoke with were aware of the trust vision and values. Staff believed that patients were looked after well, and the trust did what it could, given the financial position. The majority of staff we spoke with believed that patient care and safety had improved in recent years.
- Individual teams and their managers were aware of key performance indicators for their service, and care was based on recognised pathways. Staff told us that they felt part of the trust and understood their role in achieving goals.
- Areas which did not provide seven-day working had entered plans to develop the service. Staff in the breast clinic described proposals for increasing staffing levels during the transformation period. Some staff were apprehensive about the proposals, but stated that the trust were liaising with staff and unions.

Governance, risk management and quality measurement

- Outpatient departments and diagnostic imaging departments provided performance data to the trust board on a monthly basis. Matrons and department heads met regularly to discuss performance, staffing levels and skill mix.
- Referrals from GPs to clinic services followed accepted practice and the trust's standard operating procedures.
- Staff understood their role and function; they told us that they were proud to work at the trust, and of the relationships with patients and the wider health community.
- We saw that there were systems in place to monitor performance within teams. Regular meetings took place, where learning was shared and performance discussed.
- We saw that clinics were planned in such a way as to maximise capacity; staff and managers told us that the only way they could increase capacity was to move to seven-day working. Space and time would not allow any expansion of services within current practice.
- We saw minutes of meetings which confirmed that complaints and serious incidents were discussed to enable learning between and within teams. Staff told us that important incidents were shared across the trust, and not restricted to one site or one team.

Leadership of service

- We found that local leadership was good in most areas; staff were supported to perform their role, and we had many examples of senior staff up to matron level assisting in clinics during busy periods.
- Liaison between managers at different sites, but who were working in the same field, was excellent.
- Staff in the fracture clinic told us that the most senior member of staff in the department was a junior nurse, and if they required guidance or needed the support of a manager they had to telephone, or more usually email, their concerns. This meant that staff in the department did not always receive the support they needed.
- The trust had set a target for 75% of staff to complete their mandatory training. However, the low numbers of staff who had completed this training suggested that it was not taken seriously. Staff told us that there were no courses available. This had been highlighted at team meetings, and managers had escalated the problem, but no additional resources had been provided.
- Staff told us that they felt informed about important issues within the trust and at their own site; they said that these were discussed at team meetings, and they also received emails, and had access to the trust newsletters and information through the intranet. However, many staff said that they did not see executive level staff in the departments.
- One member of staff said “if they came and spent a day in each area then they would understand what we do and you’d feel like they valued what you do”.

Culture within the service

- Managers understood their role, and were aware of their unit’s function and importance to the trust. They understood the difficulties that staff faced with issues such as capacity, and they represented their interests at senior management meetings.

Outpatients and diagnostic imaging

- Staff told us that they had confidence in their local managers, they felt supported by them, and believed they were approachable.
- Local managers were visible to their teams, and staff told us how senior staff would often provide assistance during busy periods.
- One senior sister we spoke with told us how they saw getting involved in practice as an essential part of their role, so that they understood the pressure that their staff faced, and also to enable them to develop and maintain their own skills whilst being able to monitor and support their staff.
- Prior to our inspection we had received information which suggested that if staff complained or made a fuss, managers would try to move them and exclude them from being part of the team. During the inspection of the diagnostic services and outpatient services at the Princess Royal Hospital, in addition to speaking with staff in focus groups, we spoke with 35 staff, either individually or in small groups of two or three. None of the staff we spoke with told us that they had experienced or witnessed any unfair treatment.

Public and staff engagement

- Analysis of complaints and comments was completed at trust level; however, we were shown examples of how local information had been used in some areas to identify issues. Diagnostic services had introduced a patient feedback form; comments had identified that staff were not always as welcoming as patients would have liked. These findings were fed back to staff during meetings and resulted in staff being more aware of how their actions and behaviour impacted on patients. We were advised that comments about staff attitude reduced after the feedback was given.
- Complaints were dealt with at trust level, but we saw evidence of how complaints had been analysed and results shared with teams.
- The trust launched a Friends and Family staff test in June 2014, inviting staff to respond to the Friends and Family Test, which was usually used to survey patients; 81% of staff who responded said that they would recommend treatment and care to their family and friends. And 67% said that they would recommend the trust as a good place to work. These figures were a great improvement over the previous results, which gave only 48% and 47% respectively some twelve months previously.
- Monthly trust board meetings were held, and were open to the public to attend.
- The trust had undertaken a series of six listening events during August and September 2013 in partnership with Healthwatch Shropshire, Healthwatch Telford and Wrekin and Montgomeryshire Community Health Council, to seek the views of patients about their experiences at the trust, and how improvements could be made.

Innovation, improvement and sustainability

- Seven-day working has been proposed in clinics and areas of imaging which do not already provide seven-day cover.
- New CT scanners have been approved, which will increase patient flow and capacity.
- We were told that staff absences were covered from within clinics own staff. The cost of covering for absences was met through utilising staff who, by virtue of the NHS agenda for change, were on protected pay rates. This had meant that it was cheaper for the trust to pay these staff to work additional hours than to use bank or agency staff. The protect pay rates were due to continue for another 12 months, after which managers told us that they did not know how they would finance cover. This meant that the system was not sustainable in the long term.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had outstanding safeguarding procedures in place. The safeguarding team had links in every department where children were seen, with safeguarding information shared across the trust.
- The hospital had an Independent Domestic Violence Advisor (IDVA). The post had been substantiated through funding from the Police Crime Commissioner, due to excellent outcomes recorded by the trust. We were told that referrals from the trust to the Multi-Agency Risk Assessment Conference (MARAC) had been endorsed as excellent practice by the Co-ordinated Action Against Domestic Abuse (CAADA). CAADA is a national charity supporting a multi-agency and risk-led response to domestic abuse.
- The compassionate and caring dedication for end of life care within the renal service was outstanding, especially the development and introduction of the 'my wishes' document at the Princess Royal Hospital, for supporting people who had been diagnosed with an 'end stage' decision.

Areas for improvement

Action the hospital MUST take to improve

- The trust must review the levels of nursing staff across A&E critical care, labour ward and end of life services to ensure they are safe and meet the requirements of the service.
- Ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that further service development and learning can take place.
- Ensure that staff are able to access mandatory training in all areas.
- Review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.
- Ensure that mortuary services are safe through maintenance of this area.

Action the hospital SHOULD take to improve

- The trust should ensure that there is a designated safeguarding lead in the accident and emergency department.
- The trust should review the arrangements for visitors entering and exiting the labour ward to ensure that it does not impact on midwives workload and that in the event of an emergency, staff and patients can easily leave the department.
- The trust should ensure that the quality dashboard reports accurately reflect performance against targets at each site, and that thresholds are clear.
- The trust should review sustainability plans and budgetary support for end of life care.
- The trust should review arrangements for seven-day working in therapy and pharmacy services, to ensure wards and departments are supported over the weekends.
- The trust should ensure that medicines are held securely in surgical ward areas.
- The trust should ensure that the 'Butterfly Scheme' for dementia patients is rolled out and embedded across all wards in medicine.
- The trust should develop a strategy for the improvement and delivery of end of life care.
- The trust should review staffing and management structures for end of life care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Deceased patients were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance of the fridge storage area**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The trust must review the levels of nursing staff across A&E critical care, labour ward and end of life services to ensure they are safe and meet the requirements of the service.** **There were not sufficient paediatric trained nurses in the A&E department.** **There were not sufficient general nurses in the A&E or end of life services or midwives in labour ward.** **The critical care unit was not staffed in accordance with national guidance.** **The trust must ensure that staff are able to access mandatory training in all areas.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

The trust must ensure that all staff are consistently reporting incidents and that staff receive feedback on all incidents raised so that service development and learning can take place.

The trust must review pathways of care for patients in surgery to ensure they reflect current good practice guidelines and recommendations.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The trust must ensure that A&E and all surgical wards are able to access all the necessary equipment to provide safe and effective care. This includes defibrillators and ECG machines in the A&E department and a variety of equipment in the surgery department, especially when new wards are created.