Shrewsbury and Telford Hospital NHS Trust

Inspection report

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Date of inspection visit: 6 July, 7 July, 13 July, 14 July, 19 July, 20 July 2021, 17 August, 18 August and 19 August 2021
Date of publication: 18/11/2021

Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

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

- The Royal Shrewsbury Hospital; and
- The Princess Royal Hospital

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

During 2012/13, the Princess Royal Hospital became the main specialist centre for inpatient head and neck surgery with the establishment of a new head and neck ward and enhanced outpatient facilities. It also became the main centre for inpatient women and children's services following the opening of the Shropshire women and children's centre in September 2014.

During 2012/13, the Royal Shrewsbury Hospital became the main specialist centre for acute surgery with a surgical assessment unit, surgical short stay unit and ambulatory care facilities.

Together the hospitals have just over 800 beds and assessment & treatment trolleys. The trust operates, on average, over 5,000 outpatients' clinics per week.

The trust has over 5,800 whole time equivalent members of staff.

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

- Consultant-led outreach clinics

Our findings

- Midwife-led unit
- Renal dialysis outreach services
- Community services including Midwifery, Audiology and Therapies.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. Staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas. Services had to be redesigned and moved at short notice.

At the time of our inspection, the trust was part of an improvement alliance with an NHS trust based in Birmingham, which had commenced in 2020 and was still in operation. The alliance involved the sharing of resources, staff, expertise and learning to facilitate improvement across the trust.

We carried out this unannounced inspection of Shrewsbury and Telford Hospitals NHS Trust because at our last inspections in 2018 and 2019 we rated the trust overall as inadequate, and the trust was placed in special measures. We inspected to see what improvements had been made.

We carried out an unannounced inspection of the following acute services provided by the trust:

- Urgent and emergency care at both the Royal Shrewsbury Hospital and the Princess Royal Hospital;
- Medical care at both the Royal Shrewsbury Hospital and the Princess Royal Hospital;
- End of life services at both the Royal Shrewsbury Hospital and the Princess Royal Hospital; and
- Maternity services at the Princess Royal Hospital.

We also inspected the well-led key question for the trust overall.

We inspected these services because during previous inspections we had identified concerns and had taken enforcement action to check whether the trust had made improvements to the care and treatment delivered.

We did not inspect all the services previously rated as requires improvement because this inspection was focused only on services where we had concerns. We are monitoring the progress of improvements to services and will re-inspect them as appropriate. Services previously rated as requires improvement and not inspected this time include:

The Royal Shrewsbury Hospital:

- Surgery;
- Critical Care; and
- Outpatients.

The Princess Royal Hospital:

- Surgery;
- Critical Care; and
- Services for children and young people.

Our findings

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

- The trust had made improvements since our last inspection but further work was needed to improve the rating.
- We rated safe and responsive as inadequate and caring as requires improvement. Effective and well-led had improved to requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings.
- We rated four out of the seven services inspected as requires improvement and three as inadequate.
- In rating the trust, we took into account the current ratings of the seven services not inspected this time.
- Staff did not always assess and respond to patient risk. Records were not always of good quality, stored safely or easily available to staff to ensure that they could provide safe nursing care
- Vacancies within nursing, medical and allied health professional staffing was still impacting on the safety and quality of patient care.
- Practice in respect of infection prevention and control was varied in performance and the environment across many core services did not promote safe and high-quality care.
- Practice in relation to pain relief for patients varied across core services. The availability of key services was varied with patients not being able to access them seven days a week, especially in respect of the services provided by allied health professionals.
- Staff did not always treat patients with compassion and kindness but it is acknowledged their ability to do so was impacted by other challenges the trust faced.
- Individual needs were not always met. People could not always access the service when they needed it and did not receive the right care promptly.
- Leadership at trust level and across core services had improved but there was further work to do which included but was not limited to management of risk and performance, culture and governance.

However:

- Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- Services had improved safeguarding practices which improved safety for service users.
- Mental health provision for service users had improved.
- Actions were being taken to recruit nursing, medical staff and effective leaders.
- Medicines were generally managed well, with some exceptions in some areas. The safety culture within the trust had improved since our last inspection but learning was not always shared effectively.
- Services generally provided care and treatment based on national guidance and evidence-based practice. Staff monitored the effectiveness of care and treatment. The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients. Key services were available to support patient care. Practice in relation to Mental Capacity Act and Deprivation of Liberty Safeguards had improved across the whole of the trust.
- The board was developing and starting to work well together.

How we carried out the inspection

Our findings

We carried out this inspection on various days throughout July 2021. We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff, as well as holding focus groups.

During the inspection we visited:

- 12 wards within medical services at the Royal Shrewsbury Hospital;
- 10 wards within medical services at the Princess Royal Hospital;
- All areas of the emergency department within urgent and emergency care services at the Royal Shrewsbury Hospital;
- All areas of the emergency department within urgent and emergency care services at the Princess Royal Hospital;
- Five wards where end of life care services was delivered and the mortuary at the Royal Shrewsbury Hospital;
- Five wards where end of life care services was delivered and the mortuary at the Princess Royal Hospital; and
- All areas within maternity services at the Princess Royal Hospital.

We spoke with 192 staff members of various speciality and profession including, consultants, doctors, radiotherapists, midwives, nurses, healthcare support workers, allied health professionals, pharmacists, patient experience, domestic staff and administrators.

We spoke with 41 patients throughout the departments and reviewed 135 patient records.

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

Outstanding practice

We found the following outstanding practice:

Midwifery staff showed immense levels of resilience as they were able to continue to provide high levels of care to women and babies and maintained a positive and caring attitude during extremely challenging circumstances. The maternity department was under considerable scrutiny following the publication of the first Ockenden review (independent review of maternity services) and during the COVID-19 pandemic. This was in addition to the maternity service's ongoing challenges with the stability of the senior maternity leadership team which further impacted on staff.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 71 legal requirements. This action related to seven services.

Our findings

Trust wide

- The trust must ensure that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. (Regulation 12 (1)(2)(a))
- The trust must ensure it implements an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. (Regulation 12 (1)(2)(a))
- The trust must ensure there is a system in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional. (Regulation 12 (1)(2)(a))
- The trust must ensure practice in respect of carrying out accurate clinical risk assessment and care planning improves. This includes ensuring patients' needs are individualised, recorded and acted upon. (Regulation 12 (1)(2)(a))
- The trust must ensure it has an effective system to monitor and improve the quality of care planning records. (Regulation 17 (2)(c))

The Royal Shrewsbury Hospital Urgent and Emergency Care

- The service must ensure that staff comply with nationally recognised infection control standards. (Regulation 12(1)(2)(h))
- The service must ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. (Regulation 12(1)(2)(a)(b))
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. (Regulation 12 (1)(2)(a))
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. (Regulation 12(1)(2)(a))
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. (Regulation 12 (1)(2)(a))
- The service must ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed. This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. (Regulation 18(1)(2)(a))
- The service must ensure the (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust targets. (Regulation 18 (1)(2)(a))
- The service must ensure patients can access care and treatment in a timely way. (Regulation 12(1)(2)(a)(b))
- The service must ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. (Regulation 17(1)(2)(a)(b))
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is checked in line with guidance to ensure it remains in date and available for use. (Regulation 12 (1)(2)(e) and (f): Safe care and treatment.)
- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. (Regulation 17(1)(2)(c))

Our findings

- The service must ensure that all patients have a pain assessment at triage, and regularly monitored for pain throughout their time in the ED, and suitable analgesia must be prescribed and provided. (Regulation 12 (1)(2)(a)(b))

The Royal Shrewsbury Hospital Medical Care

- The service must ensure that there are adequate numbers or nursing, medical and therapy staff to provide safe and effective care and treatment. (Regulation 18 (1))
- The service must ensure that policies and procedures which are in place to prevent the spread of infection, are followed by all staff at all times. (Regulation 12 (2)(h))
- The service must ensure that there is effective cleaning of medical wards and that checklists are completed to evidence this. (Regulation 15 (1)(a)(2))
- The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes but is not limited to; venous thromboembolism (VTE), falls, pressure care, and fluid balance monitoring. (Regulation 12 (1)(2)(a)(b))
- The service must ensure that deteriorating patients are identified and escalated in line with trust policy. (Regulation 12 (2)(a))
- The service must ensure that medical patients have their individual needs assessed and that care planning is personalised to meet individual needs. (Regulation 9 (1)(2)(3))
- The service must ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. (Regulation 17 (2)(c))
- The service must ensure effective systems are in place to learn from audit, outcome and performance data in order to make improvements to the quality and safety of patient care. (Regulation 17 (1)(2)(a))
- The service must ensure there are adequate risk oversight systems in place to identify, review and mitigate risks within the service. (Regulation 17 (2)(b))
- The service must ensure that all equipment safety checks are completed in line with testing frequencies identified in the trust policy. (Regulation 15 (1)(e))

The Royal Shrewsbury Hospital End of Life Care

- The service must ensure staff are competent in their roles. This includes but is not limited to infection prevention control, mental capacity, deprivation of liberty and Mental Health Act training. (Regulation 12 (1)(2)(c) and (e))
- The service must ensure all risks associated to the health and safety of service users receiving care or treatment are assessed and reviewed regularly. (Regulation 12(1)(a))
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. (Regulation 18 (1))
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. (Regulation 18 (1))
- The service must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted as part of care planning and specialist team intervention. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b)).

Our findings

- The service must ensure all patients receive medicines when they are prescribed and without delay to avoid harm to the patients who use the service. (Regulation 1212(1)(2)(g))
- The service must ensure service users are treated with dignity and respect. (Regulation 10(1))
- The service must ensure staff receive appropriate clinical supervision to ensure they are competent and skilled in order to carry out their role. (Regulation 18(1)(2))
- The trust must ensure it had full oversight of end of life care services, develops a robust programme of audit to monitor outcomes for patients and fully embeds the end of life care team into the governance processes. (Regulation 17(1)(2)(a))
- The service must have an effective system which accurately identifies, triages and tracks end of life and palliative care patients. (Regulation 17(1) (2)(a))
- The service must ensure all risks identified through governance processes are identified, recorded, reviewed and mitigated. (Regulation 17(1)(2))

The Princess Royal Hospital Urgent and Emergency Care

- The service must ensure that staff comply with nationally recognised infection control standards. (Regulation 12(1)(2)(h))
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. (Regulation 12 (1)(2)(a))
- The service must ensure patients can access care and treatment in a timely way. (Regulation 12(1)(2)(a)(b))
- The service must ensure records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. (Regulation 17(1)(2)(c))
- The service must ensure refrigerators for the storage of medicines within the department are monitored effectively in order to store medicines safely. (Regulation 12(1)(2)(e)(g))

The Princess Royal Hospital Medical Care

- The service must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. (Regulation 9)
- The service must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. (Regulation 9)
- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b))
- The service must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. (Regulation 12(2)(h))
- The service must ensure environmental risks are appropriately assessed and mitigated. This includes but is not limited to; environmental hazards, ward-based storage, patient equipment and security. (Regulation 12(1)(2)(d))
- The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, repositioning, fluid balance monitoring, diabetic patient needs and pre-existing medical conditions and behaviours that challenge. (Regulation 12(1)(2)(a) and (b))

Our findings

- The service must ensure that medical patients at risk of developing a pressure ulcer have their needs continually assessed, the appropriate equipment in place and on-going records updated in relation to pressure care. (Regulation 12(1)(2)(a) and (b))
- The service must ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs, care planning and management. (Regulation 12(1)(2)(c) and (e))
- The service must ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. (Regulation 17(1)(2)(c))
- The service must ensure effective systems are in place to effectively identify and share learning from incidents to prevent further incidents from occurring. (Regulation 17(1)(2)(b))
- The service must ensure effective systems are in place to consistently assess, monitor and improve patient safety, quality and outcomes of care provided. This includes but is not limited to processes to identify where quality and/or safety are being compromised, quality and safety audits and incident investigation oversight processes including quality improvement oversight. (Regulation 17(1)(2)(a) and (b))
- The service must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. (Regulation 17(1)(2)(a))

The Princess Royal Hospital End of Life Care

- The service must ensure staff are competent in their roles. This includes but is not limited to infection prevention control, mental capacity, deprivation of liberty and Mental Health Act training. (Regulation 12(1)(2)(c) and (e))
- The service must ensure that premises and equipment is maintained to prevent and control the spread of infections that are health care associated. (Regulation 12(1)(2)(e)(h))
- The service must ensure all risks associated to the health and safety of service users receiving care or treatment are assessed and reviewed regularly. (Regulation 12(1)(a))
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. (Regulation 18(1))
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. (Regulation 18(1))
- The service must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted as part of care planning and specialist team intervention. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b))
- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. (Regulation 17 (1)(2)(b))
- The service must ensure all patients receive medicines when they are prescribed and without delay to avoid harm to the patients who use the service. (Regulation 12(1)(2)(g))
- The service must ensure service users are treated with dignity and respect. (Regulation 10(1))
- The service must ensure staff receive appropriate clinical supervision to ensure they are competent and skilled in order to carry out their role. (Regulation 18(1)(2))

Our findings

- The service must ensure it had full oversight of end of life care services, develops a robust programme of audit to monitor outcomes for patients and fully embeds the end of life care team into the governance processes. (Regulation 17(1)(2)(a))
- The service must have an effective system which accurately identifies, triages and tracks end of life and palliative care patients. (Regulation 17(1)(2)(a))
- The service must ensure all risks identified through governance processes are identified, recorded, reviewed and mitigated. (Regulation 17(1)(2))

The Princess Royal Hospital Maternity Care

- The service must ensure that the emergency buzzer in the Wrekin midwifery led unit is operational to alert all relevant staff to an emergency. (Regulation 12(1)(2)(a)(b))
- The service must ensure staff complete required training for safeguarding children and adults training, PREVENT and Mental Capacity Act 2005 and Deprivation of Liberty Safeguards in line with the trust target. (Regulation 12(1)(2)(c))
- The service must ensure staff are able to access and update women's electronic records in the birthing rooms in the Wrekin midwifery led unit. (Regulation 17(1)(2)(c))

Action the trust SHOULD take to improve:

The Royal Shrewsbury Hospital Urgent and Emergency Care

- The service should ensure that all medicines are stored securely and correctly with restricted access to authorised staff.
- The service should ensure that emergency medicines are always available within the ED.
- The service should ensure the privacy and dignity of patients is protected at all times. The service must ensure that patients within all areas of the ED consistently have their right to privacy respected.
- The service should ensure that all relevant risks within the ED are included and planned for in the service's risk register.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for.
- The service should consider new ways of consistently involving patients in the plans to improve their ED services so they reflect the needs of the local population.
- The service should consider reviewing the contents of their action plans in relation to their RCEM audit results and ensure they are effectively driving improvements and demonstrating good patient outcomes.

The Royal Shrewsbury Hospital Medical Care

- The trust should ensure that all staff within the medical care service complete the mandatory training assigned to them.
- The service should review the consistency of decision making processes for administering medication that controls people behaviour, such as rapid tranquilisers.
- The service should ensure all staff complete the mandatory safeguarding training assigned to them.

Our findings

- The service should consider if complaints information is widely displayed so that patients know how to complain.
- The service should consider how all patients can have access to consultant review seven days a week.
- The service should consider how it can meet the requirement to provide therapy services over seven days
- The service should consider using the security systems in place, such as medical records trolleys locks and secure ward entry systems, to reduce the risk of unauthorised access to records and ward areas.
- The service should consider using a system for recording the site of application or removal of transdermal medicine patches.
- The service should consider how medicines are stored on AMU to ensure they are organised and tidy.
- The service should consider patients privacy and dignity and ensure this is maintained during all care provision
- The service should review the use of communication support resources, including interpreting services and communication books and consider if they are used appropriately.
- The service should consider if individual patient needs in relation to patients living with dementia are fully met.
- The service should consider if there is an adequate process for all ward staff to consistently receive relevant information, especially on wards where staff meetings are not routinely held.

The Royal Shrewsbury Hospital End of Life Care

- The service should ensure patients are referred for end of life care in accordance with the General Medical Council guidance.
- The service should audit the recording of consent within the service to ensure records are fully completed.
- The service should develop an effective process to monitor patient outcomes for the services users requiring end of life or palliative care.
- The service should ensure all members of the end of life and specialist palliative care team are included within the governance structure and communication systems.
- The service should ensure information is available in accordance with the accessible information standards.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

The Princess Royal Hospital Urgent and Emergency Care

- The service should ensure the nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates.
- The service should ensure the privacy and dignity of patients is protected at all times.
- The service should ensure that patients within all areas of the ED consistently have their right to privacy respected.
- The service should ensure that all relevant risks within the ED are included and planned for in the service's risk register.

Our findings

- The service should consider how to effectively display patient safety information within the ED, including waiting times.
- The service should consider reviewing the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.

The Princess Royal Hospital Medical Care

- The service should ensure timely access to Computerised Tomography (CT) scans for patients with a suspected stroke.
- The service should ensure deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital.
- The service should ensure key information is shared and documented when handing over care from one ward to another.
- The service should ensure all new and temporary medical staff have timely induction and access to electronic patient record systems.
- The service should ensure the equipment used for providing care or treatment to a service user is safe for such use and safety checks are carried out.
- The service should ensure there is a system in place for recording the site of application or removal of transdermal medicine patches.
- The service should ensure all staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them.
- The service should ensure patients requiring swallow screening and assessment have these completed in a timely manner to ensure people who use services have adequate nutrition and hydration to sustain life and reduce the risks of malnutrition and dehydration while they receive care and treatment.
- The service should ensure all premises and equipment is suitable for the purpose for which they are being used and properly maintained.
- The service should ensure that effective processes are in place to investigate and respond to complaints in line with trust policy.
- The service should ensure nursing and medical staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them.
- The service should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues.
- The service should ensure all staff have timely access to electronic records to enable them to undertake their role effectively.

The Princess Royal Hospital End of Life Care

- The service should ensure patients are referred for end of life care in accordance with the General Medical Council guidance.
- The service should audit the recording of consent within the service to ensure records are fully completed.

Our findings

- The service should develop an effective process to monitor patient outcomes for the services users requiring end of life or palliative care.
- The service should ensure all members of the end of life and specialist palliative care team are included within the governance structure and communication systems.
- The service should ensure information is available in accordance with the accessible information standards.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

The Princess Royal Hospital Maternity Care

- The service should ensure there are enough midwifery staff to meet minimum safe staffing levels, allow staff to be released to conduct mandatory training and ensure staff can take their breaks.
- The service should ensure that skills drills are conducted in all parts of the maternity unit including at night.
- The trust should ensure all women have one-to-one care.
- The service should ensure they audit data to evidence they are complying with recommended sepsis pathway timelines, such as women receiving antibiotics within 60 minutes.
- The service should ensure the service has a comprehensive programme of repeated audits to check improvement over time.
- The service should ensure all nursing and midwifery staff rotate to different areas of the maternity unit to ensure they maintain up-to-date skills.
- The service should ensure investigations into staff performance are investigated in a timely way.
- The service should ensure maternity safety champions meet regularly with the trust level safety leads to escalate locally identified issues.
- The service should ensure the new midwifery leadership structure is implemented in a timely way.
- The service should ensure the date risks are added to the risk register are recorded to enable service leaders to monitor whether risks are mitigated in a timely way.
- The service should consider incident reporting when actual staffing levels fell below planned levels to evidence the regularity and impact of the reduced staffing levels.
- The service should consider including baby abduction drills in maternity specific training to ensure all staff know what to do in emergency situations.
- The service should consider either soundproofing the bereavement suite or re-locating it away from the delivery suite.
- The service should consider using the maternity dashboard to monitor workforce performance indicators such as sickness, mandatory training compliance and skills and drills to improve compliance and identify areas for improvement.
- The service should consider continuing to improve their engagement with the clinical staff.

Our findings

- The service should consider clearly displaying safety information in clinical areas for staff and visitors.

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement because:

- Within the leadership team, there were gaps in experience and a potential risk of instability.
- Staff had mixed views regarding the visibility and how approachable trust leaders were.
- The trust had a vision for what it wanted to achieve but did not yet have an overarching trust wide strategy to turn it into action.
- Staff feelings regarding feeling respected, supported and valued were mixed but there had been significant improvement since the last inspection.
- The trust was at the start of its equality and diversity agenda work.
- Governance processes required further development to assure they were aligned with strategic, operational and clinical risk.
- A review of and improvement of the board assurance framework and risk registers was required.
- The trust did not always collect reliable data and analyse it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed to understand performance, make decisions and improvements.
- There were areas identified for improvement at our last inspection which were still of concern. Understanding of good quality improvement methods was mixed and staff did not always have the capacity to be effective in implementing improvement initiatives. There was limited evidence that innovation was encouraged.

However:

- The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them.
- The trust had a vision for what it wanted to achieve and the vision was focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.
- Staff were focused on the needs of patients receiving care and the trust promoted an open culture where patients, their families and staff could raise concerns without fear.
- Leaders were generally clear about their roles and accountabilities but there was some overlap which meant roles and responsibilities could be unclear. They had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance.
- Most relevant risks and issues were identified and escalated and actions to reduce their impact were implemented.
- Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff were engaging with patients, staff, equality groups, the public and local organisations to plan and manage services but feedback needed to be collated and used to formulate the trust's strategy and improvement plans. They collaborated with partner organisations to help improve services for patients.

Our findings

- Generally, all staff were committed to continually learning and improving services.
- Work was being carried out to improve patient outcomes.

Leadership

Leaders had the skills and abilities to run the trust but there were gaps in experience and capacity. They understood the priorities and issues the trust faced. Staff had mixed views regarding the visibility and how approachable trust leaders were. They supported staff to develop their skills and take on more senior roles.

The trust board was currently still developing as a leadership team. As a leadership team, they mostly held the appropriate range of skills, knowledge and experience to perform its role. There had been many changes to the board since our last inspection but with the new additions, it was developing and starting to work well together.

The leadership team, including the non-executive directors, understood the priorities and issues they faced. It was acknowledged by the board the trust was on an improvement journey and further work was required to ensure quality and safety were assured.

Some roles within the board had been appointed to on an interim basis which was a potential risk to stability within the leadership team. However, we were told, although we did not see, there was a strategy for addressing this with plans to appoint to permanent positions.

Within the leadership team, there were gaps in experience, due to the number of interim appointments of first time executive posts, but this had been identified and was being mitigated using seconded experienced leader support from a local NHS trust. It was also being addressed through the implementation of board development plans, focusing on unitary board concepts and development of strategy planning.

There were gaps in leadership below those at director level. There were posts at deputy director level which had not yet been recruited to which meant aspects of the large and complex portfolios, held by directors, could not be delegated. However, recruitment was beginning to take place, specifically at deputy director of medicine level.

The trust had a lead for child and adolescent mental health, learning disability and autism. This role was held by the interim director of nursing, who was supported in this role by their deputy director of nursing and specialist nursing leads for both adult and children's mental health.

Fit and Proper Person checks were in place, were appropriate and in line with the regulations.

Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an "unfit person" or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed.

The trust leadership team had comprehensive knowledge of current priorities and challenges and took action to address them. It was recognised by the trust that leadership at divisional level needed to be clinically led. The decision was taken to ensure each directorate had a triumvirate of a divisional clinical director, head of nursing and head of operations. The changes had been made not only to improve the voice of the clinicians but also cohesiveness, effectiveness and accountability. The success of the restructure was not yet known as it had only recently been implemented. Some divisional leadership triumvirates had developed faster than others.

Our findings

Leadership development opportunities were available, but at the time of our inspection the focus was on staff at band 8b or above. The programme was focused on developing their self, team and organisation for the ultimate benefit of patient care and experience. It included content to support senior leaders to develop as leaders, change agents and managers throughout and after the programme.

The executive board were working to gain the trust of divisional and local leaders as there had been frequent changes in key roles. This work was acknowledged by staff working within divisions and throughout the trust, including at non-executive director level. Executive directors, specifically the director of nursing and the co-medical directors, visited wards before board meetings to improve visibility but also to gain an understanding of the issues in areas they visited. However, we carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 30% of staff said that they had confidence in the executive team.

Vision and Strategy

The trust had a vision for what it wanted to achieve but did not yet have an overarching trust wide strategy to turn it into action. The vision was focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The vision of the trust was to provide excellent care for the communities they served. The values were partnering, ambitious, caring and trusted. The leadership team were invested in the values and staff knew what they were. They had been developed following engagement with staff.

There were multiple workstreams addressing the trust strategy, but they had not yet been brought together, as the overall trust strategy was still being developed. It was anticipated that a refreshed strategy would be completed before the end of December 2021. The trust did not have a specific strategy document which encompassed all of work they were doing to achieve their vision, however, they did have a methodology and framework for “getting to good”. This was being used to review the trust’s areas for development across all their divisions, the actions they were taking to address them and to monitor their progress over time.

Steps had been taken to engage with divisional teams and staff to begin the process of formalising a trust wide strategy. Within divisions, strategies were being developed which were in line with the trust’s priorities, but further work was still required at trust level to ensure all strategies were aligned to what the trust wanted to achieve. A workshop with clinical support services had taken place before our inspection and workshops with divisions were going to take place through September 2021.

Local providers and people who use services had been involved in developing the strategy. The trust was working with their local integrated care system (ICS) to ensure both strategies were aligned. The trust was also working with other local NHS trusts, outside of their ICS, to develop pathways and services to improve patient care for those within and outside of their community. For example, work was being done with others to improve critical care, interventional radiology and pathology services.

Further development, to gain full assurance of the quality of care improvement, was required. The importance of improvement in patient care and treatment was being expressed but further work was needed to ensure that it results in improvement in care and delivery.

Our findings

Not all staff felt confident any changes to the organisation would be implemented effectively. We carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 26.8% of staff agreed that "This organisation introduces and implements organisational change well".

Culture

Staff feelings in regard to feeling respected, supported and valued were mixed but there had been significant improvement since the last inspection. Staff were focused on the needs of patients receiving care. The trust was at the start of its equality and diversity agenda work but promoted an open culture where patients, their families and staff could raise concerns without fear.

Improvements had been made in the number of staff who felt respected, supported and valued. Across core services, there was a mixed perspective amongst staff, with some positive in how leadership made them feel, but others felt less valued and respected.

The trust's vision and values underpinned a culture which was patient centred. Everyone at both executive level and divisional level expressed compassion for the wellbeing of staff. Most leaders spoke about the need to be inclusive but it was recognised further work was needed to ensure they were meeting the needs of all of their staff.

In general, staff felt positive and proud about working for the trust and their team.

Leaders and staff at all levels were concerned about and recognised, following the pandemic, the wellbeing of the workforce and continued support was required to support recovery of exhaustion. This included ensuring psychological support was available to all staff.

The trust recognised staff success by staff awards and through feedback.

There had been improvements in how the trust engaged and worked with trade unions. Trust policies were also becoming more transparent and were being reviewed when concerns or issues were raised to ensure they were clearer to follow and promote consistency of practice.

Managers addressed poor staff performance where needed. Action was taken when performance or behaviours were not in line with expectations. However, there were concerns grievance processes were not always effective. This had been raised at appropriate forums and reviews of policies had been carried out as a result.

The trust had appointed a Freedom To Speak Up (FTSU) Guardian and staff were supported to raise concerns. Processes had been reviewed to enable the Guardian to report to the board on a quarterly basis. In between reporting, the guardian had monthly meetings with the heads of nursing and the non-executive director lead. They also worked with human resources and employee relations to work collaboratively to find solutions to some of the concerns raised.

Staff felt able to raise concerns without fear of retribution. Staff raised concerns or issues with their managers and would also report through the FTSU process.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Reporting to the FTSU Guardian had increased since our last inspection with 302 contacts in 2020/21 being reported, and 100 contacts in

quarter one of 2021/22. There were areas which needed to be improved, which included but was not limited to addressing themes and trends and creating action plans to address. For example; triangulating allegations of bullying and harassment to ensure what was raised by staff was being addressed effectively. Also, there was no equality data monitoring which meant there was a lost opportunity to use this data to monitor themes in those raising concerns.

The trust applied Duty of Candour appropriately. We reviewed seven serious incident reports and found the trust had followed the appropriate Duty of Candour processes. There was an up to date policy and most staff were aware of and could apply Duty of Candour principles.

At the time of our inspection, not all staff had the opportunity to discuss their learning and career development needs at appraisal. However, the trust had performed well in light of the Covid-19 pandemic as 85% of staff had an appraisal against a national target of 90%.

Rates in respect of sickness, turnover and temporary staff usage were higher than the national average. The trust had undertaken a programme to recruit oversea nurses and were on track to fill vacancies.

Not all staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. According to the trust's Workforce Race Equality Standard (WRES) annual report from 2020, there had been some overall improvements but their performance was worse than the England average in a number of metrics, across Black, Asian and Minority Ethnic (BAME) staff. For example, in respect of staff experiencing harassment, bullying or abuse (35% against the England average of 29%); equal opportunities for career or promotion (71% against the England average of 74%); experiences of discrimination from a manager/colleagues (16% against an England average of 14%). However, the trust had identified actions to address areas of poor performance which had resulted in improvements over time in most metrics.

The trust was involved in a piece of work with a local university to look at rural racism following reports of racism experienced by a small number of overseas nurses.

The equality, diversity and inclusion (EDI) programme of work within the trust was at its early stages and required further development to ensure it led to improvements in both staff and patient experience. Resources were limited but an EDI manager, band seven, was in post. Work around the EDI agenda within the trust was not embedded and was in its infancy. There was limited focus on EDI in relation to patients and service users.

The trust had recognised the importance of EDI but the pace of delivery to improve it within the organisation was slow. A piece of work had been commissioned at board level which identified three key priorities, which were to consider the leadership on the inclusion agenda, focus on EDI at board level and support for the EDI lead. However, no action plan had been developed to address this.

There were limited staff networks which promoted the diversity of staff. Within the trust there was a race, disability and pride network but these had only been recently set up. The networks only encompassed some but not all staff diversity and membership within the networks was low and varied in terms of stability.

We carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 34% of staff agreed that "The organisation values staff and provides them with effective support to do their jobs to the best of their ability". Reponses for all other questions in the survey were less positive however noting these respondents were a small number of the total staff employed, whilst respecting and acknowledging their responses we were unable to come to any significant conclusions.

Our findings

Governance

Governance processes required further development to assure they were aligned with strategic risk. Leaders were generally clear about their roles and accountabilities but there was some overlap which was not entirely clear. They had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had structures, systems and processes to support the delivery of its strategic aims which included sub-board committees, divisional committees, team meetings and senior managers. However, the governance processes in operation throughout the trust were not standardised and therefore had varying levels of effectiveness. It was acknowledged some processes at each level of governance required further development to provide assurance to leaders at both local and board level they were aligned with strategic and clinical risk. There was a committee structure but as it was in the process of being reviewed, so it was not fully operational.

The committee structure had been streamlined and improvements to the effectiveness of the committee meetings had been made. However, there was a potential risk some issues and risks did not have the appropriate attention, time and scrutiny dedicated to it. For example; the trust did not have a dedicated workforce board sub-committee. Workforce related issues were fed into the finance and performance committee. This was a potential risk due to the fact many of the trust's challenges were workforce related and did not have the same level of scrutiny from trust leadership. An operational workforce group had been established which fed into the finance and performance committee. It was focused on workforce and safety but did not have the same status as a dedicated workforce committee and did not have a non-executive director chair.

Papers for board meetings and other committees had improved with most containing appropriate information. However, improvement was required to ensure reliable assurance was present within minutes and reports through each stage of the governance process. There were concerns information within reports was not always triangulated.

Non-executive and executive directors were clear about their areas of responsibility but it was recognised further development was required. For example, development sessions were being carried out to look at the executive directors' and non-executive directors' role in reviewing and challenging the board assurance framework.

Governance arrangements in relation to Mental Health Act administration and compliance were in place but further work was required to ensure its importance across the trust was embedded. The practice, performance and focus on compliance with the Mental Health Act had improved but further improvements were not aided by the fact the trust did not have a non-executive lead for mental health or that they did not have a dedicated mental health and learning disability operational group. It was hoped by the leads within the trust one could be created to help force through the work that needed to be done. However, mental health was included as an agenda item within governance processes. For example, it was discussed at heads of nursing meetings.

There was a framework which set out the structure of ward/service team, division and senior trust meetings but as governance structures across the organisation were not standardised, the flow of information was not as effective as it could be.

Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. However, further development needed to take place to ensure action plans were reviewed and progressed.

Our findings

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Business cases were reviewed by the finance and performance committee.

At the time of our inspection, we were told that there were some board committees which took place after board papers should be produced. As a result, the trust was going to rearrange when board meetings take place to ensure there was enough time to complete the required work between committee and board meetings.

The trust faces significant challenges. The recently appointed finance leadership team were implementing remedial financial governance processes and systems at pace. The design and implementation of these systems and processes was encouraging, and to be encouraged.

There was early evidence of an improvement trajectory through the stabilisation of run-rate expenditure, the strengthening of the financial leadership team, full and transparent engagement in recovery activities, a clearer organisational shared understanding of the casual effects of underlying deficits, greater clarity regarding the improvement activities that are necessary to remedy the financial challenges, and improving relationships and confidence in the trust from regulatory and system partners.

The recency of these actions was such that further improvement was required to demonstrate a sustainable and consistent improvement trajectory.

The trust was credibly forecasting achievement of the agreed financial outturn for Half 1 (H1) of 2021/22, which will be the first time in 4 years that the trust has delivered against the requirements.

There had been a significant improvement in engagement and transparency with system partners and Regulatory bodies. The trajectory to improvement remains in its infancy and the evidence of sustained and embedded improvement will only be persuasive if the trust continues to deliver against these commitments in 2021/22.

The finance leads demonstrated a clear understanding of the drivers of the deficits of the organisation and have strengthened and improved the systems of control and oversight necessary to assess progress and delivery.

The trust has high levels of agency spending. The recruitment to substantive posts was significantly dependent upon overseas recruitment. The increased investment in substantive posts was based upon a reduction in temporary and premium pay locum costs. The trust's history of delivery of productivity and efficiency savings was not strong. The trust hospital transformation plan required detailed and challenging workforce transformation plans. These risks were recognised as critical to the delivery of trust strategic objectives. The oversight and scrutiny of these workforce and transformation plans was an essential source of assurance to the organisation.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. A review of and improvement of the board assurance framework and risk registers was required, but this was recognised by leaders. Most relevant risks and issues were identified and escalated and actions to reduce their impact were implemented. They had plans to cope with unexpected events but they were not always effective.

Our findings

The trust had systems to identify learning from incidents and safeguarding alerts and make improvements but not all learning was identified. We reviewed six serious incident reports and generally, most learning had been recorded but within two investigation reports, additional lessons and actions should have been identified.

It was not always clear learning had been identified during the investigation of complaints. Within three of the five complaint responses we reviewed, the learning sections were blank. Another response had only been partially completed. In each response actions had been identified in each of the responses.

Dissemination of learning from incidents was not always effective. As part of our inspection, we carried out a staff survey which covered many aspects in respect of working for the trust. One question specifically related to the sharing of information in relation to incidents. According to the results only 59% of staff said that they heard about incidents in their part of the organisation and the learning from them and only 38 % had said they heard about incidents and the associated learning from other parts of the organisation. We also saw that even when learning had been identified, it was not always embedded.

Senior management committees and the board reviewed performance reports. The trust had a finance and performance committee which had sight of an integrated performance report. Members of the committee reviewed data to assess the trust's performance. However, the performance metrics were predominantly nursing focussed and there were areas of performance and quality which were missing. Leaders regularly reviewed performance but improvements were not always made, despite actions being taken.

Processes in relation to identifying, recording and mitigating risk required improvement. However, staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

The trust was aware their board assurance framework (BAF) and corporate risk register needed to be reviewed and improved. The BAF was focused predominantly on operational risks and did not contain any strategic risks. The trust did not have a specific corporate risk register but used a refined trust wide risk register, which contained over 100 risks. This did not allow for detailed conversation around the highest and most concerning risks within the trust.

Each risk on the trust wide risk register recorded the risk, causes and effect, risk score, risk controls, actions required, responsible person and when actions needed to be implemented by. However, not all risks had been updated with progress notes. We were told risks for review by the trust board should be scored 15 or above, however, this did not always appear to be the case. It was therefore unclear, which risks would need to be escalated to the trust board.

Risk registers were in operation at each core service level but there was variation in how they were reviewed, their content and in their effectiveness. For example; evidence was limited on when risks had been reviewed and some registers did not contain all identified risks. We were told, but were not provided with any evidence, that a review process had been discussed and plans had been implemented to start work on reviewing and improving these processes. In addition, training around these processes was being provided to the trust board to build further understanding.

The trust had recognised assurance was needed to ensure divisions know and have plans to address performance issues. The trust and divisions have developed an integrated performance report (IPR) which used data across different metrics to demonstrate how each specific division was performing. Each IPR was reviewed periodically to review and challenge performance. Actions were then taken to address areas of improvement. Areas of concern were escalated, especially if there were repeated issues in the management of performance. However, performance monitoring of the end of life care services was limited, there were no systems to monitor quality or key performance indicators.

Our findings

The quality of the data used to monitor performance was not always acceptable. We were told and could see data relating to performance did not always make sense and they was an acknowledgement that there was not absolute confidence in it. Despite this the trust were taking steps to make improvements. This could be seen through the trust's maternity improvement plan. The trust maintained oversight of the plan using data and could identify improvements over time but also address any dips in performance and implement effective actions.

Performance in respect of responding to complaints required improvement. At the time of our inspection, the trust had a backlog of 100 complaints. The trust had started a mapping process to identify barriers to responding to complaints in a timely way. However, the trust did not have a clear trajectory of when they would be able to clear the backlog.

Information Management

The trust did not always collect reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were not integrated but they appeared to be secure. Data or notifications were consistently submitted to external organisations as required.

The board received information on service quality and sustainability. As mentioned above, the board received an integrated performance report for each division within the trust. However, it was acknowledged the data set contained in the reports needed to be reviewed to ensure the board were sighted on all the necessary information as some metrics were omitted. For example, not all the necessary national indicators were included in the integrated performance report dashboard reviewed at board level. For example; it did not include the metric in relation to sepsis, however, it was included at board committee level. There were some concerns over the level of assurance the reports provided. Some were not assured they had access to all necessary information but everyone felt they could challenge its reliability.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust.

The trust was aware of most of its services' performance through the use of key performance indicators (KPIs) and other metrics through the use of divisional and trust wide integrated performance reports, with the exception of specialist palliative and end of life care services.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, locum doctors did not have access to trust communication platforms which meant access to important safety updates was limited. and were often missed out of meetings where information was shared. This was not on the service risk register.

Not all board and senior staff expressed confidence in the quality of the data but challenge was welcomed.

Information was not always in an accessible format, timely, accurate and identified areas for improvement. Trust guidelines and policies were not always stored in the most accessible way and there were issues with version control. Work was also being carried out to review current policies to ensure they were compliant. The trust used both paper and electronic records across divisions and throughout the trust. This made access to information more difficult. The trust did have plans to implement more electronic recording systems across the trust.

Systems were in place to collect data from wards/service teams.

Our findings

Staff did not always have access to the IT equipment and systems needed to do their work. For example, within the Wrekin midwifery led unit.

Leaders submitted notifications to external bodies as required.

There were information governance systems but they did not always protect the confidentiality of patient records. Poor practice was identified across multiple core services in relations to the security and confidentiality of patient records.

Engagement

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

The trust was beginning to develop a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust had a director of public participation who was working with stakeholders and community groups to engage and draw the thoughts, ideas and feedback into the trust to help shape and improve services.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

The trust did engage with people and staff in some equality groups. However, more work was required to ensure all staff had a voice.

The trust had a structured and systematic approach to staff engagement. For example, the trust held staff engagement sessions on the improvement alliance with a local NHS trust, to explain the nature of the alliance and its impact. The trust had also introduced a monthly cascade briefing as part of a formal cascade mechanism.

Staff were involved in decision making about changes to the trust services. Staff had been able to engage in process to gather feedback and ideas on service developments.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. For example, at quarterly board meetings time was given to hear from patients/families to share their stories in relation to their experiences while using services provided by the trust.

Division leaders/middle managers, on behalf of front-line staff, did not engage with external stakeholders such as commissioners and Healthwatch. The engagement with Healthwatch, when it did take place, was at executive leadership level.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was working with their local integrated care system (ICS). They were also actively engaged with healthcare providers outside of their ICS to improve care pathways and services to ensure effective and sustainable care for those in their communities.

Our findings

External stakeholders said they received open and transparent feedback on performance from the trust. However, some felt their importance was not rated as highly as other stakeholders.

The trust had engaged with external stakeholders and system partners to start making improvements to services. For example; improvement work within children and young people's services was being carried out, in partnership with system partners, to address safety issues and better meet the needs of those who used the service.

Learning, continuous improvement and innovation

Generally, all staff were committed to continually learning and improving services, however, there were areas identified for improvement at our last inspection which were still of concern. Understanding of good quality improvement methods was mixed and staff did not always have the capacity to be effective in implementing improvement initiatives. There was limited evidence that innovation was encouraged but there was some participation in research. Work was being done to improve patient outcomes.

There was limited evidence the trust was actively seeking participation in national improvement and innovation projects. The trust expressed a desire to improve the care and treatment provided within their organisation but we were not provided with evidence demonstrating participation in national projects. The trust was working with two trusts to share learning to improve services, specifically in maternity.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. For example; during the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

There were organisational systems to support improvement work. For example; there was a planned programme of work, known as "Getting to Good", which was monitored and reported on weekly. There was a structured two-year plan which included a committee, chaired by the Chief Executive Officer, who maintained oversight of progress.

Systems were in place to identify and learn from unanticipated deaths, however resources dedicated to this were limited which impacted on the ability to improve the system. The trust had an up to date policy which set out the process to follow. We reviewed three learning from deaths records and found that all appropriate steps had been taken to ensure all learning could be identified. Families were encouraged to be involved with the process and there was appropriate partnership working internally and with external partners. The team dedicated to facilitating the learning from deaths initiatives was composed of a mortality lead and a medical examiner, but only the mortality lead was in a full time post. There was support from a medical examiner manager and a medical examiner service manager.

We reviewed five complaints and one did not meet the trust's response target but updates were provided to the complainant. One complaint had been reviewed by the Parliamentary and Health Service Ombudsman who had identified the trust's original response was not adequate.

Staff did not always have time and support to consider opportunities for improvements and innovation. However, there was areas of improvements throughout the trust. For example, process and practice regarding mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards had improved across the trust.

Our findings

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. For example; members of the end of life care team had been awarded the Dundas medal for their work 'taste for pleasure' work using a patient's favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

Data was being used to drive improvement. However, as stated above under "Management of risk, issues and performance" and "information management", data sets and streams were being reviewed and improved to ensure it could be used more effectively.

There were processes to identify learning but further development was required to ensure it was embedded and consistently used to drive improvement and outcomes for patients.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔➔ Nov 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Shrewsbury Hospital	Inadequate ➔➔ Nov 2021	Requires Improvement ➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ➔ Nov 2021	Inadequate ➔➔ Nov 2021
The Princess Royal Hospital	Inadequate ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021
Bridgnorth Community Hospital	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Oswestry Maternity Unit	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Ludlow Community Hospital	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall trust	Inadequate ➔➔ Nov 2021	Requires Improvement ➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ➔ Nov 2021	Inadequate ➔➔ Nov 2021

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

Rating for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Inadequate ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ↓ Nov 2021	Inadequate ↓ Nov 2021	Inadequate ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔➔ Nov 2021
Maternity	Inadequate Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Outpatients	Requires improvement Apr 2020	Not rated	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Overall	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔➔ Nov 2021	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔➔ Nov 2021

Rating for The Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Good ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Services for children & young people	Inadequate Apr 2021	Inadequate Apr 2021	Requires improvement Apr 2020	Inadequate Apr 2021	Inadequate Apr 2021	Inadequate Apr 2021
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Requires Improvement →← Nov 2021	Inadequate ↓ Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Requires Improvement ↑ Nov 2021	Good ↑↑ Nov 2021	Good ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Maternity	Requires Improvement →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021
Outpatients	Good Apr 2020	Not rated	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Overall	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Requires Improvement →← Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021

Rating for Bridgnorth Community Hospital

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

Rating for Oswestry Maternity Unit

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

Rating for Ludlow Community Hospital

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

Royal Shrewsbury Hospital

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

Description of this hospital

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

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

The urgent and emergency care service provides services 24 hours a day, seven days a week. The service consists of a booking reception area, a main waiting area, a children's waiting area, two adult triage rooms, four bedded resuscitation bay, 12 majors' cubicles, 'pit stop' with four trolleys, four bedded clinical decisions unit (CDU), one children's cubicle and one children's triage room.

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

The end of life care service comprised of two service lines, a specialist palliative care team and an end of life care team. The palliative care team at Shrewsbury and Telford Hospitals NHS Trust works across both hospitals. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

During our inspection we visited all areas within urgent and emergency care, ward 22 (short stay), 22 (respiratory), 23, 28 (frailty and gen med), 27 (general med), 23 (oncology), 24c (cardiology), 24E (endocrinology), 32 (respiratory), 35 (nephrology), 36, acute medical unit, surgical assessment unit and endoscopy.

We spoke with 86 members of staff, including doctors, nursing staff of various grades, healthcare support workers, physiotherapists and managers. We spoke with 21 patients and we looked at 79 sets of patient records.

Medical care (including older people's care)

Requires Improvement  

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

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

Nursing staff received mandatory training but not all staff kept up to date with this. Data provided by the trust showed that not all staff were compliant with mandatory training requirements. The trust target for training compliance was 90%. Data provided by the trust following our inspection showed that for additional clinical services staff (healthcare assistants and nursing associates) four out of ten training sessions met the target compliance. For registered nursing staff six out of ten sessions met the target compliance. For therapy staff six out of ten sessions met the target compliance. Where target compliance was not met for training sessions, it was close to the target for most sessions. The training sessions with the lowest level of compliance were information governance and basic life support (BLS). Nursing staff told us that they had training sessions cancelled when staffing levels were reduced. Some staff told us they did not have time to complete online learning during a shift and had to complete this in their own time at home. There was not a consistent approach across ward managers for staff to be given the time back or additional pay for these hours.

Medical staff received mandatory training but not all staff kept up to date with this. Data provided by the trust following our inspection showed that for medical staff two out of eight required training sessions met the target for compliance. Where target compliance was not met for training sessions, compliance rates were variable. The training sessions with the lowest level of compliance for medical staff were information governance, patient moving and handling and basic life support.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training topics included fire safety, infection prevention and control, hand hygiene, patient moving and handling, adult basic life support, food safety and hygiene, conflict resolution, equality and diversity, information governance, and health and safety. The majority of training sessions were completed as online learning.

Clinical staff did not consistently complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The service provided data for completion of Mental Capacity Act (MCA), Deprivation of Liberty Safeguarding (DoLS) and Mental Health Act (MHA) training. Average compliance for completion of these training sessions across staff groups in medicine was 73%. Medical staff had the lowest overall compliance for these training sessions at 44%.

There was no requirement for clinical staff to complete mandatory training in learning disabilities, autism or dementia. However, the dementia specialist nurses told us that all staff were expected to complete tier one dementia training as a workbook. The aim was for 90% compliance for completion by September 2021. Dementia awareness was not listed as

one of the mandatory training sessions in the information provided by the service, and no data for completion of this training was provided. Tier two training was available to senior staff such as ward managers and this was in the early stages of being rolled out to staff. Learning disability e-learning and training workshops were available but were not mandatory.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us that compliance was monitored through a corporate education team who sent monthly compliance reports to ward managers. The ward manager reminded any staff who were not compliant to update their training. Staff compliance with training was reported by each ward to the matrons and head of nursing in a monthly meeting.

Safeguarding

Most staff had completed training appropriate to their role on how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to apply safeguarding knowledge.

Most nursing staff received training specific for their role on how to recognise and report abuse. Data provided showed the target for adult safeguarding level two training was met and was almost met for safeguarding children level two training.

Additional clinical services staff (healthcare assistants and nursing associates) received training specific for their role on how to recognise and report abuse. Data provided showed that 92% had completed safeguarding adults level two training and 93% had completed safeguarding children level two training. This met the trust target for completion of safeguarding training of 90%.

Most medical staff received training specific for their role on how to recognise and report abuse. Data provided showed that 94% had completed safeguarding adults level two training and 82% had completed safeguarding children level two training. Compliance with children's safeguarding training did not meet the trust target of 90%.

Most therapy staff had received training specific for their role on how to recognise and report abuse. Data provided by the trust showed that 90% of therapy staff had completed safeguarding adults level two training and 88% had completed safeguarding children level two training. This almost met the trust target for completion of safeguarding training of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they would raise a safeguarding concern and could explain the process for escalating concerns and reporting them to the local authority. The safeguarding specialist nurse team worked closely with the local authorities in the region to manage safeguarding referrals and processes.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw 'Safeguarding is everyone's responsibility' information displayed on medical records trolleys. This provided staff with information and advice on how to report safeguarding concerns.

Staff were supported in managing safeguarding concerns by a specialist safeguarding nurse team who provided training and advice.

Staff usually followed safe procedures for children visiting the ward. However, at the time of our inspection, visiting was restricted, and no children were allowed to visit due to the COVID-19 pandemic.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. However, they kept equipment and the premises visibly clean.

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

The service generally performed well for cleanliness. Hospital wide (patient led assessments of the care environment (PLACE) scores for 2019 were 99.57% for cleanliness.

Cleaning records were not up to date. The service had a process for twice daily cleaning tasks to be carried out using a checklist to evidence completion. This was in line with the trust operational cleaning policy. During our inspection we saw that daily cleaning schedules were not always fully completed. We reviewed 12 copies of daily cleaning schedules during our inspection and found significant gaps in completion. None of the 12 schedules were fully completed. The trust told us that at the time of inspection there was no reference to deep cleaning in the cleanliness policy. The policy was under review as part of the work on implementing the National Standards of Healthcare Cleanliness and there was a plan to add deep cleaning to the policy. The service told us they performed reactive specialist cleaning during or after periods of infection outbreak. In addition, they undertook proactive specialist periodic cleaning as an annual programmed clean of wards. Cleaning records showed that reactive decontamination had been completed in side rooms and bathroom areas when a patient with an infectious illness was moved to another ward or area. The service used automated room decontaminations systems using hydrogen peroxide vapour or ultraviolet light for this process. Cleaning records for the three months before our inspection did not provide any evidence of proactive decontamination. The service could not demonstrate that all areas were cleaned in accordance with the trust operational cleaning policy.

Staff did not always follow infection control principles, including the use of personal protective equipment (PPE). We observed that some staff were entering wards without decontaminating their hands which was not in line with trust policy. Whilst all staff wore face masks, not all staff were clear on the trust's policy on their use. Staff we spoke with told us they were required to change their mask on entering a ward, but this was not outlined in trust policy. This only applied if patients had aerosol generating procedures in a bay, which required masks to be worn on entry to that area and removed on exit. We saw that where there were infectious patients in side rooms, there were clear signs on the door to make all staff aware of required precautions. However, on two occasions we witnessed staff entering patient isolation rooms without appropriate PPE. We did see that staff were bare below the elbow in line with infection prevention and control guidance.

Hand hygiene audits and infection prevention and control audits were completed monthly on all wards. Audit results showed that compliance with audit standards was mostly good. The medical wards achieved the trust target of over 90% most of the time in both audits. However, the infection prevention and control audit data for March 2021 showed that none of the medical wards achieved the target. Average compliance of medical wards in March 2021 was 79%.

We saw that there were hand hygiene posters above clinical handwashing sinks that reminded staff of effective hand washing techniques.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that 'I am clean' stickers were routinely used on patient equipment to indicate that the item had been cleaned after use and was ready for the next patient to use.

The service had adopted clear curtains between bed spaces, which were wipe clean. This was to promote social distancing in line with COVID-19 guidance. It also allowed patients and staff to see each other when their privacy curtains were open.

Wards had adopted the use of 'ready rooms' to create additional isolation facilities when these were required for patients with infectious illnesses.

All patients were regularly tested for COVID-19 using polymerase chain reaction tests. They were tested on the day of admission, on days three and five following admission and weekly thereafter. However, staff were not routinely tested unless they were symptomatic, or they were working in an area where there had been a COVID-19 outbreak. There was a voluntary lateral flow testing process which staff could choose to consent to. Data provided by the trust showed that on average, 18% of frontline staff had participated in the lateral flow tests from April to June 2021.

Wards had spill kits to enable the safe collection and disposal of blood and other body fluids in the event of a spillage.

In the endoscopy department we saw that dirty equipment was kept separate from clean equipment and was decontaminated in a separate area. There was an endoscope decontamination policy which detailed the requirements for cleaning and disinfecting endoscopic equipment. Staff followed this to reduce the risk of infection for service users and staff following contact with a piece of equipment used in the patient care process. The trust had also adopted the British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal endoscopy. I am clean stickers were placed on the clean endoscopes and traceability stickers were used in patient records. A log was kept of each endoscope used detailing the brand and type of scope, serial number, decontamination method, and patient use identification. This meant that there was full traceability of the scopes and a record of their decontamination.

We saw that staff in the endoscopy department changed their PPE (masks, aprons and gloves) between each patient.

Hospital acquired infection rates from April 2020 to March 2021 for the Royal Shrewsbury Hospital, showed there was one case of Methicillin-resistant Staphylococcus Aureus (MRSA), 12 cases of Methicillin-susceptible Staphylococcus Aureus (MSSA) and eight cases of clostridium difficile and four catheter associated urinary tract infections.

We requested water sampling certificates for endoscopy and Legionella and Pseudomonas certificates, but the service did not provide these. However, the service sent us the trust Legionella Control Association (LCA) certificate which was valid until 31 August 2021. LCA certificates demonstrate that providers have complied with the LCA code of conduct and service standards and are committed to preventing legionellosis and keeping their water systems safe. They also sent the trust water safety plan which was a draft version from 2016. This incorporated Legionella and Pseudomonas aeruginosa, "safe" hot water, cold water, drinking water and ventilation systems management and control. There was no evidence of this plan being signed off. We were not assured that there were effective water safety systems in place.

Environment and equipment

The design and use of facilities and premises kept people safe. However, equipment was not in date for annual safety checks. Staff did not manage clinical waste well.

Patients could reach call bells and staff responded quickly when called. All patient beds had access to call bells, and we saw that these were left where patients could access them. Staff completed two-hourly comfort assessments with all patients which included checking that patients had access to a call bell. We observed that staff responded quickly when patients used the call bell.

The design of the environment followed national guidance. Each ward was a mixture of single sex bays and side rooms. There were identified toilet and bathroom facilities for each bay or side room. However, some wards were cluttered with equipment. There were cleaning trolleys, patient records trolleys, computer trolleys and equipment such as wheelchairs in the ward corridors. This meant it could be difficult for patients to safely navigate the environment.

Staff carried out daily safety checks of emergency equipment, however, annual safety tests on equipment were not up to date. Resuscitation equipment for use in an emergency was available in all areas we visited. Staff carried out daily safety checks of resuscitation equipment. We saw the daily checks were in place across all wards we visited. There was a trust process for new devices to be identified with a yellow new equipment tag and then added to the equipment database. Once equipment items had been tested, they were released for use and added to a maintenance database. We saw a log for 435 items of equipment within the medical service. We found that 336 (77%) of these equipment items had not been tested within the planned testing date. The longest delay in testing was 829 days after the planned testing date. Equipment items included thermometers, monitors, suction pumps, scales, syringe drivers and infusion pumps. However, all items of equipment we checked during our inspection had stickers to identify they were in date for testing. We were not assured that there was a robust process for maintaining equipment to ensure it was safe for use.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to equipment they required to carry out their role, such as equipment for patient observations, hoists and commodes. We saw that equipment such as beds and bedrails was in good condition. Wards had store rooms that contained consumables such as dressings and fluids. Store rooms were tidy and well organised and there was a process in place for monitoring stock levels and expiry dates of items.

Staff did not always dispose of clinical waste safely. We saw that there were waste bags on the floor on some ward corridors. When bins were full, waste bags were removed and replaced but the full waste bags were not always removed from the clinical environment in a timely way.

Wards were not secure, there was no secure entry and exit system in use on most wards. There were intercom entry systems, but these were not being used on most wards we visited and doors to wards were unlocked. This meant that anyone could enter or leave the ward, including unauthorised visitors and patients on DoLS who were not free to leave.

Cleaning products subject to the control of substances hazardous to health (COSHH) regulations were not always stored securely. We saw that a cleaning trolley which held hazardous substances was stored in the corridor of one ward. The cleaning cupboards in the store room on the renal ward were not locked meaning anyone could access hazardous cleaning products, including patients. Cleaners told us this was since there was only key for the cupboards, so they had to be left unlocked to allow all cleaning staff to be able to access them. We raised this during our inspection and immediate action was taken to resolve the concern. A system was put in place where the key was kept securely with other ward keys under the control of the ward sister / manager. This meant the cupboards could be locked but cleaning staff could still access them as required. As a longer term solution, we were told that a digital door lock would be ordered to keep the store room secure.

Assessing and responding to patient risk

Staff did not consistently complete and update risk assessments for each patient or take actions to remove or minimise risks. Staff did not always identify or quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not always escalate them appropriately. Staff used the National Early Warning Score (NEWS) system to monitor patients at risk of deterioration. We saw evidence that NEWS scores were routinely completed on appropriate patients. Any patient with a NEWS score of 3 or above was

highlighted during the shift handover and board round. However, deteriorating patients were not always escalated in line with trust process. There was a critical care outreach team of doctors and nurses who could be bleeped for urgent review of deteriorating patients. Staff evidenced escalation of deteriorating patients by the use of a yellow sticker in the patient's medical records. We saw evidence of these stickers being used in some of the records we reviewed. There was a daily process for ward managers to review all records of patients who had scored a NEWS of five and above in the previous 24 hours, to monitor if they had been appropriately escalated in line with the trust policy. Data from this review process for a 12-week period from March to June 2021 showed that 76 patients on medical wards at the hospital did not have documented evidence of timely escalation when triggering a NEWS score of five or more. In addition, there was a weekly sepsis screening audit which monitored whether patients with a triggering NEWS had been escalated and received appropriate treatment. We reviewed data for these audits for the same time period and saw that there was variable compliance for escalating patients with a triggering NEWS score. For 11 out of 12 weeks there were some medical wards scoring amber (less than 90%) or red (less than 80%) for compliance with the audit standard for appropriate NEWS escalation. During the 12-week period there were 11 occasions of medical wards scoring amber for compliance and 18 occasions of medical wards scoring red for compliance with appropriate NEWS escalation. We were not assured that deteriorating patients were consistently escalated appropriately.

There was a sepsis care bundle tool kit used to identify key elements of care regarding the diagnosis and treatment of patients with suspected sepsis to enable consistent and timely treatment. Wards had a sepsis trolley which contained equipment for treating patients with suspected sepsis and this was checked daily. However, data provided by the trust showed that the sepsis care bundle was not always implemented appropriately for deteriorating patients. For a 12-week period from March to June 2021, there were nine weeks where some medical wards scored amber or red for compliance with the audit standard of following clinical response guidance. During the 12-week period there were six occasions when medical wards scored amber for compliance and 10 occasions of medical wards scoring red for compliance with following clinical response guidance. We were not assured that deteriorating patients consistently received timely treatment.

Staff did not always complete all risk assessments for each patient on admission or review these regularly. Although staff used recognised tools within a nursing assessment booklet, these were not consistently completed for all patients, for all risks, and were not always reviewed and updated in line with trust policy. For example, we reviewed 12 falls risk assessment tools within nursing records and found that although all 12 records had an initial falls risk assessment completed, eight of the 12 had no re-assessment documented. We reviewed 20 venous thromboembolism (VTE) risk assessments and found that two patients had not had a VTE risk assessment on admission and 15 patients had not had a reassessment within 72 hours. We reviewed 10 pressure risk assessments and found that although all 10 records had an initial risk assessment, three had no weekly re-assessment. We were not assured that comprehensive risk assessments and reviews of risk assessments were consistently carried out on all patients.

Staff did not always know about any specific risk issues as the risk assessment tools were inconsistently completed. When risks were identified there were associated management plans in the nursing assessment booklet, but these were not always fully completed. We saw that six patients identified as a high falls risk had incomplete or blank management plans. Another patient had an identified action in the falls management plan to refer to therapy but there was no evidence that this action had been completed. A patient identified as high risk on a pressure assessment did not have any pressure prevention plan documented. We saw that in five repositioning charts we reviewed, none of these were fully complete. Staff did not routinely document which position a patient had been moved from and to, or the required frequency of repositioning. This meant that staff may not always be redistributing the pressure on a patient's skin in order to relieve pressure and prevent pressure sores. We were not assured that all risks identified on nursing assessments were managed positively in order to keep patients safe. However, we saw that when patients had a high risk of VTE, they were on appropriate prophylactic treatment to reduce the risk.

The service had a 'think yellow' campaign to highlight patients at risk of falls. Any patient identified at risk was given a yellow wrist band to wear so that staff could easily see they were at increased risk of falling. In addition, these patients had a falls icon displayed on a patient board above their bed and on the patient status at a glance board.

Patients at high risk of falls were put on enhanced supervision observations where appropriate. The need for enhanced patient supervision (EPS) was determined through an initial risk assessment and daily review. This meant that patients may be nursed in a cohort bay with additional staff observing patients in the bay or may receive one to one supervision if the risk was identified as high. Staff observing patients in a cohort bay operated a tagging system. Staff wore a yellow tagging badge and needed to keep the patients in line of sight at all times. They could not leave the bay without passing the tagging badge to another member of staff. We observed this process on one ward and saw that staff followed the procedure as set out in the policy. Observations of patients receiving one to one supervision should be documented hourly in accordance with the trust's enhanced care policy. Enhanced patient supervision records for three patients showed that for one patient receiving one to one supervision observations had not been documented on the previous day. The service did not currently audit against this policy.

Staff on ward 22 told us that there was reduced visibility into some side rooms which made patient observation difficult. They explained that this had impacted on the frequency of patient falls in the past, but they had increased staffing levels on the ward in mitigation of this.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff were supported by a specialist mental health liaison team who provided a 24-hour response service. Each area had a special mental health resource file for information and advice.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff were able to access a consultant psychiatrist through the mental health liaison team for any patients with complex mental health needs.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed board rounds between nursing, medical and therapy staff. All staff involved were given a written handover document which summarised key information about each patient in a situation, background, assessment, recommendation (SBAR) format. SBAR is a recognised tool for structured communication of critical information.

Patient's requiring a procedure in the endoscopy department were offered a pre-procedure assessment if they had certain conditions such as diabetes or were taking medication such as anticoagulants (blood thinning medication). Any diabetic patients had a glucose sticker placed in their records and were prioritised on the procedure list for the beginning of the day. In the event of an unexpected complication during a procedure, such as a gastrointestinal bleed, staff would involve the resuscitation team and the named gastroenterologist for the day. Staff followed national guidance for safety standards for invasive procedures (NATSSIPS) and had developed local guidance (locSSIPS) based on these. Following an endoscopy procedure, patients went from the procedure room to the recovery area where their observations were monitored using an adapted National Early Warning Score (NEWS) system. Patients could only be discharged if their NEWS score was less than two. The service had a set of criteria for nurse-led discharge of outpatients using the endoscopy service.

Staff in the endoscopy department used World Health Organisation (WHO) checklists to ensure that patient safety was communicated by the team of operating room professionals. There was one overall WHO checklist report submitted for the trust. This included audits for areas where endoscopy procedures were undertaken but was not specific to endoscopy. Audit results from January to June 2021 showed 100% compliance for each standard audited; team brief, time out, sign out and completion of the WHO checklist.

All patients should have timely access to consultants for assessment in order to identify and respond to any risks. The trust provided trust wide data for compliance with standards within the seven day services self-assessment tool relating to consultant assessment. The most recent data available was for March 2020. Achievement of the target for 90% of patients to be assessed by a consultant within 14 hours of emergency admission was not met. Trust data showed that 65% of patients were seen within this timeframe. Achievement of the target for 90% of patients on an established care pathway to see a consultant at least once a day was not met. Trust data showed that 75% of patients saw a consultant at least once a day. Achievement of the target for 90% of high dependency patients to receive a twice daily review by a consultant was not met. Trust data showed that 57% of high dependency patients saw a consultant twice a day.

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. During our inspection, staff told us that there were not always enough staff to provide care. Ward managers and matrons told us that staffing concerns were on their risk registers. Band 7 staff in ward manager roles were covering clinical work on some wards due to reduced staffing on the day of our inspection. The number of nurses and healthcare assistants did not always match the planned numbers. Planned and actual staffing numbers displayed for wards we visited showed that actual staffing levels did not always meet planned staffing levels. Managers could escalate reduced actual staffing levels, but they did not always receive additional staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers told us that there was a continued cycle of nursing recruitment for vacancies. Recruitment plans were in place for vacancies at the time of our inspection. Managers told us that some vacancies had been filled and were awaiting staff start dates and further recruitment adverts were out. There was an ongoing programme of international nurse recruitment and a new cohort of international nurses were planned to start in the service by September 2021. To mitigate vacancies in the interim period the service used temporary staff (bank staff and agency staff) and overtime where required.

The ward manager could adjust staffing levels daily according to the needs of patients. There was a matron on each site each day who performed a safe staffing overview. Wards used a nationally recognised tool to calculate required staffing levels for each shift on each ward. The matron held a daily safety brief call with ward managers from all wards to check staffing levels, skill mix and acuity. Matrons planned staffing for 24 hours ahead and kept a staffing spreadsheet of agreed and actual staffing numbers for each ward. This enabled the matron to identify if there were unfilled shifts so this could be escalated, and mitigations could be put in place. Mitigations included moving staff to different wards if there

was an area of greater need, or the use of temporary staffing. Staffing rosters were approved at least six to eight weeks in advance to make sure the right skill mix was put in place. When there were high numbers of patients with enhanced care supervision needs, managers were able to request additional staff to support these needs. This was usually provided in the form of bank or agency staff.

The service had high vacancy rates for registered nursing staff. Data from July 2020 to June 2021 showed an average vacancy rate of 15.8% for registered nursing staff.

The service had lower vacancy rates for nursing support staff. Data from July 2020 to June 2021 showed an average vacancy rate for health care assistant (HCA) staff of 5.3%

As a result of vacancies and sickness, the service had high rates of bank and agency nurses and HCA staff usage on the wards. From June 2020 to May 2021 a total of 31.5% of all registered nursing shifts and 38% of all HCA shifts were covered by non-substantive staff. Managers were unable to limit their use of bank and agency staff and were dependent on non-substantive staff to cover unfilled shifts. However, through the use of bank and agency staff, the service managed to cover the majority of required shifts. From June 2020 to May 2021 there were only 0.3% unfilled registered nursing shifts and 0.95% unfilled HCA shifts.

Managers made sure all bank and agency nursing staff had a full induction and understood the service. We saw that agency staff were orientated to the ward at the beginning of their shift and completed an induction checklist with the nurse in charge.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. Data showed that the service reported an overall surplus of 8.5% medical staffing across all medical staff grades. However, there was a vacancy rate of 17.0% for consultants. The overall surplus staffing was made up of 14.3% over-staffing of middle grade medical staff and 36% over-staffing of junior grade medical staff. The highest consultant vacancy rates were in general medicine, cardiology and nephrology. We saw there were four whole time equivalent (WTE) budgeted consultant staff in cardiology but two of these posts were filled by locum consultant staff as the service had experienced difficulty in recruiting consultant cardiologists.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Data showed that there was a budgeted establishment of 70.6 WTE medical staff which were skill mixed across different grades. However, the actual skill mix in post across different medical grades did not match the planned budgeted skill mix. The trust had not been able to recruit to the establishment for all grades of doctor: they mitigated the shortfall in consultants and doctors in training by over recruiting middle grade doctors.

The service had high rates of bank and locum staff. Managers told us this was to provide additional numbers to the staffing establishment to address the pressures during COVID-19. The trust told us that medical staff bank hours, locum hours and unfilled hours could not be calculated as a percentage of available hours as this was not recorded on their

roster system. Instead, the trust provided fill rate data. This showed that managers could not always access bank and agency when they needed additional medical staff. Not all medical shifts requested to be filled by bank staff were filled. The lowest bank staff fill rates were for consultants in renal medicine However, most medical shifts requested to be filled by agency staff, were filled, with the exception of acute medicine where there were low agency fill rates for consultants and foundation year one doctors. This specialty accounted for nearly half of the shifts that were requested to be covered by agency staff in medicine.

AHP staffing

The service did not have enough therapy staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and escalated concerns about staffing levels, but these were not always acted on. There was not evidence that bank and agency staff received a full induction.

The service did not have enough therapy staff to provide the right care and treatment. Therapy managers used an algorithm for safe staffing levels and that therapy staffing was consistently below the safe staffing levels. There was an aspiration for all patients to get all the therapy they needed but managers told us they could not meet this within the current staffing establishment. Safe staffing was the number one concern for therapy managers. Staffing concerns had been escalated to senior managers and staffing was on the corporate risk register with a score of 20 (the highest possible score). Therapy staffing concerns had been on the trust risk register for four years, but managers told us it was not the trust board's highest priority. Therapy managers mitigated the staffing issues by completing a monthly forward view of staffing requirements. There was regular use of bank and agency therapy staff. There was a plan to review staff skill mix to help better manage the demands on the therapy service. Managers hoped to improve staff retention through offering rotations across organisations and offering career development opportunities such as apprenticeships and advanced practitioner roles. They recognised that the ability to recruit enough new staff to meet the requirements of seven-day rota working was a huge challenge.

There was a prioritisation system which placed inpatients in three priority groups depending on the urgency of their needs. Managers told us that staff were rarely able to see the lowest level three priority patients due to limited staffing capacity.

Therapy staffing data showed that there were not high numbers of vacancies. However, therapy staff we spoke with told us that were unable to see patients for ongoing treatment and had to focus on patients who were medically fit for discharge. Although there were not high numbers of vacancies, there were not enough therapy staff within the budgeted establishment to meet the demands of the service.

Managers did not make sure locum therapy staff had a full induction to the service before they started work. One locum therapist we spoke with told us they had not received any induction. They were allocated to different wards on a daily basis.

Records

Staff kept detailed records of patients' care and treatment. Records were not always organised, up-to-date, or stored securely. However, all records were kept in records trolleys which were easily available to all staff providing care.

Patient notes were not always comprehensive. We reviewed 40 records and found that risk assessment documents and required action plans were not consistently completed. In addition, fluid balance and repositioning charts were not fully completed, and allergies were not routinely documented in patient's records.

Medical care (including older people's care)

All staff could access patient records easily. Records were multidisciplinary; therapy staff documented findings in the medical records. Nursing and medical records were kept together in the records trolleys. This meant that all staff were able to access all patient records when required.

Records were not stored securely. We found that records trolleys which held medical and nursing records were generally left unlocked even though digital coded locks were on each trolley. In addition, patient notes were left open and unattended and were not always locked away in the records trolleys. Observation charts holding personal information were routinely left outside of ward bays. Managers told us that these charts were removed from patient's bed sides to outside of the bay to comply with COVID-19 infection prevention and control recommendations. However, this meant that there was potential for unauthorised people, including non-clinical members of staff, ward visitors and patients to access records.

Records storage was not well organised, and we saw that there were a lot of loose sheets and documents in record sets that had not been securely filed. This meant that patient information could go missing or become part of another patients records in error. Nursing records were not always stored in folders and we saw that some were held together by treasury tags. This was not secure and meant that parts of the record could become detached and lost.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff didn't always follow systems and processes when safely prescribing, administering, recording and storing medicines.

The pharmacy team ensured there was a patient centred approach to medicine optimisation. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

Although staff knew the routes to contact pharmacy to obtain medicines, we found medicines were not always available to administer to patients. Due to the COVID-19 pandemic the pharmacy missed dose audits could not be undertaken, although the next audit was planned to be undertaken during July 2021. However, compliance was still monitored via the completion of the matron quality audits on a monthly basis. The results submitted for the hospital showed an average compliance of 80% from January 2021 to June 2021.

Managers told us there was a system for recording the site of application or removal of transdermal medicine patches, but staff told us the process was still under development and was awaiting approval at the time of our inspection. The system was not, therefore, consistently used by staff at the time of the inspection. Such a system is important to check that the patch is still in place or to prevent the application of other patches in error. Also, to communicate information about patches when a person is transferred between wards or other healthcare settings.

Staff were not always able to review patient's medicines and provide specific advice to patients and carers about their medicines.

Doctors were not always able to check patients prescribed medicines and allergies because they did not all have access to the patient's summary care records. This presented a risk when assessing and treating patients when they were admitted. We reviewed one patient who was not administered their prescribed medicines on admission because they had not brought in their medicines and there was no record of their regular prescribed medicines.

Medical care (including older people's care)

Members of the pharmacy team regularly reviewed patients' medicines throughout their admission and prior to discharge. This involved counselling and discussions with patients wherever possible.

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy.

Medicines were stored safely and securely apart from the Acute Medical Unit (AMU). Despite a weekly top up service by pharmacy, which included tidying up the cupboards, we found an untidy and poorly managed system of medicine storage within AMU. This was brought to the attention of the ward manager.

FP10 prescriptions were stored securely with a robust checking system to track their use.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines.

Medicine optimisation was undertaken by members of the pharmacy team. Any discrepancies were immediately identified and highlighted to the relevant team.

Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The antimicrobial stewardship pharmacist undertook reviews and snap-shot audits which highlighted any areas for improvement.

Dedicated sepsis trollies or boxes were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use. Venous thromboembolism (VTE) protocols were in place. Checks to ensure any necessary prescribing for the prevention of a VTE were undertaken by pharmacists.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Any medicine incidents would be reported onto the incident reporting system. Learning from incidents would be shared across the trust.

Decision making processes were not always in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), medicines were not always appropriately prescribed and monitored. We reviewed the medicine records for two patients. The Standard Operating Procedure for rapid tranquilisation had been followed for one patient and the decision-making process was

documented along with an assessment of the patient's mental capacity. However, the other patient's records showed that staff administered medicines to control their behaviour with no prior attempts to using calming or distraction techniques. There was no reference in the medical notes or care plans to guide staff on how to de-escalate situations to avoid the use of medicines.

Incidents

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

All staff knew what incidents to report and how to report them. All staff had access to an electronic incident reporting system and could explain what concerns they would raise as an incident.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The trust had an incident reporting policy which staff in the medical care service followed.

The service had no never events on any wards but did have a never event in the endoscopy department in January 2020. This involved the wrong patient undergoing a procedure in error. Managers shared learning about never events with their staff and across the trust. During our inspection we saw evidence that learning had been shared and appropriate actions were in place to prevent a recurrence. Staff told us that new documentation was now used to ensure the correct patient was presenting for the procedure. The learning and actions were shared at safety huddles, team meetings and through social media closed communication groups.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medical care at Royal Shrewsbury Hospital which met the reporting criteria set by NHS England from July 2020 to June 2021.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed at daily ward safety huddles and team meetings, where these were held. Senior staff shared national patient safety alerts in a structured way to ensure that learning from these was disseminated to all relevant staff.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers investigated incidents in accordance with guidance in the clinical incident management policy. Incidents were investigated on varying levels depending on the severity of the incident. There was a patient safety team who supported staff to identify when to carry out differing levels of investigation. Managers investigated incidents and completed reports identifying required actions and feedback. Patients were involved in agreeing key lines of enquiry for incident investigations when they met the criteria of moderate harm or above. Patients and/or their family had the opportunity to discuss incident investigation findings with staff.

Managers debriefed and supported staff after any serious incident. The ward manager on one ward explained how they had spoken with staff following an inquest outcome for a patient that had been on the ward. They told us how they had shared the inquest outcome with staff and given them the opportunity to discuss and reflect on the learning identified.

Medical care (including older people's care)

Safety Performance

The service did not always use monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors but there was not evidence that information was used to improve safety.

The service continually monitored safety performance. Safety performance dashboard data was displayed on most wards for staff and patients to see. Quality boards displayed data demonstrating the ward compliance with nursing quality assurance audits. This included data for skin integrity, falls and infection prevention control (IPC). Wards RAG rated the performance as red, amber or green to indicate levels of compliance with the quality assurance standards.

The safety performance data did not show that the service achieved harm free care within the data period information was provided for. The service provided safety performance dashboard data from March to May 2021. It was not clear if this data was site specific or service specific. The data showed that there was underperformance for falls, skin integrity, and IPC which were all rated amber for overall compliance. The service did not provide any further data to compare trends over time.

Staff used the safety performance data to identify areas requiring improvement. However, there was not evidence that improvements were achieved or sustained. We saw that there was a monthly integrated performance report to board which included a quality summary presented by the director of nursing. Safety performance was monitored through a monthly review of the service achievement of the safety metrics against target performance. Where issues in safety performance were identified there were associated actions set out to make improvements. However, safety performance dashboard data did not always show improvement in areas of poor performance.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment guidelines based on national guidance and evidence-based practice. However, staff did not always follow this guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had up-to-date policies to plan and deliver high quality care according to best practice and national guidance, however, staff did not always follow guidance. The service had a range of policies to support staff to deliver appropriate care. There were policies for pressure ulcer prevention and the prevention and management of inpatient falls which referenced the most up to date National Institute of Clinical Excellence (NICE) guidance. There was a process in place to review any new guidelines published and identify any changes in practice that were required based on these. However, we saw that staff did not always follow guidance outlined in these policies. For example, the inpatient falls policy identified the need for staff to reassess patient's falls risk assessments as a minimum every seven days and also when a patient's condition changed, or they fell. In eight out of 12 falls risk assessments we reviewed there were no reassessments. We reviewed 10 pressure risk assessments and found that three records had no evidence of reassessment and two had no documented pressure management plan despite the patients being identified as high risk. This was not in line with the trust policy.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not identify any patients who were detained under the Mental Health Act during our inspection. Staff were able to tell us what they would do or who to contact for advice and support if they were caring for a detained patient. There was a mental health specialist team who supported the service in improving quality of care for patients living with mental health conditions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that nursing handover documents identified where patients were suffering from anxiety or depression. We heard discussions about doctors having conversations with relatives and carers to ensure they understood the care plans for their loved ones.

Nutrition and hydration

Staff could not be sure they gave patients enough food and drink to meet their needs and improve their health. However, they used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff could not be sure that patients had enough to eat and drink, including those with specialist nutrition and hydration needs. There was inconsistent completion of fluid and nutrition charts meaning staff were not accurately monitoring if patients' dietary requirements were being met.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition but did not complete these consistently. Data from the performance dashboard from March to May 2021 showed that nutrition risk assessment tools were red rated for compliance with 79% of assessments being completed.

Staff did not accurately monitor patients fluid intake. Data from the performance dashboard from March to May 2021 showed that completion of fluid balance charts was red rated for compliance with 72% being completed. During our inspection we reviewed 14 fluid balance charts and saw that 13 of these were incomplete. We found there were missing entries, input and output volumes were not totalled and overall fluid balances were not calculated. This meant that staff did not accurately monitor patients fluid intake to ensure that they were sufficiently hydrated. We saw that two of the patients whose charts we reviewed had entries in their medical notes stating to encourage fluids. Despite this, neither of these patients had fully completed fluid balance charts.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Ward staff were able to contact the therapy centre and request assessments from specialist staff for patients with specific nutritional needs.

Patients were given meal choices and hot drinks were offered in between meals. Staff provided patients with a menu and supported them to make appropriate meal choices. Any patients with special nutritional needs were identified to the ward hostess and appropriate food choices were overseen by the ward manager for those patients on special diets. There were icons on boards above patients' beds indicating if they had any special nutritional requirements. Special diets to meet patients cultural and religious needs were available. Soft and pureed diets were offered to those patients with swallowing difficulties where appropriate.

Pain relief

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

Staff assessed patients' pain using a recognised tool. Pain scores were assessed and recorded regularly. We saw these were documented in all endoscopy records and most ward patients records that we reviewed. We saw that staff asked about pain levels during routine regular comfort assessments completed with all ward patients. The service told us that they used the Abbey pain scoring system as a method for identifying the signs of pain in people with communication difficulties, for example those living with dementia. However, we did not see this in use in the records that we reviewed.

Patients received pain relief soon after requesting it. In the endoscopy service we saw that pain relief was administered promptly in response to a patient expressing they were experiencing pain.

Staff prescribed, administered and recorded pain relief accurately. Medicine charts we reviewed confirmed pain relief was prescribed and delivered appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The endoscopy service had been accredited under the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) scheme. However, staff did not always use the findings to make improvements and outcomes for patients did not always meet expectations.

The service participated in relevant national clinical audits. Audits included the National Lung Cancer Audit, National Audit of Dementia, National Audit of Inpatient Falls, and National Diabetes Inpatient Audit. The service did submit some data to the Sentinel Stroke National Audit Programme but the main site for acute stroke care was at the Princess Royal Hospital so the data for the Royal Shrewsbury Hospital was not comparable to other acute stroke units.

Outcomes for patients were varied and did not always meet expectations, such as national standards. The National Lung Cancer Audit results were based on 2018 data. This showed that the service performed as expected for three metrics and worse than expected for the other two metrics. We asked the service for action plans in relation to the national lung cancer audit performance, but they did not provide these.

In the 2019 National Audit of Dementia Royal Shrewsbury Hospital was in the bottom 25% for three out of four metrics. This meant that it was performing poorly in comparison to other national providers. We asked the service for action plans in relation to national audit of dementia performance, but they did not provide these. However, the service provided a dementia workplan dated June 2020 which targeted some of the audit metrics. There were actions in relation to staffing, partnership working, assessment and care planning, the environment and governance.

The National Diabetes Inpatient Audit results were based on data from September 2019. These showed mixed performance with lower than national average performance in the staffing structure, clinical outcomes and harm domains. There was similar to national average performance for patient experience and better than national average performance for visits from a specialist team. We asked the service for action plans in relation to the national diabetes audit performance, but they did not provide these.

The national audit of inpatient falls the trust provided annualised values based on 8 cases averaged over 12 months to the end of April 2021. This showed that the trust performed worse than the national average in two domains and about the same as the national average in one domain.We asked the service for action plans in relation to the national inpatient falls audit performance and they provided a falls prevention plan based on findings from a thematic review of inpatient falls. Most of the actions identified were marked with the status of ongoing.

Medical care (including older people's care)

Outcome data was reviewed at specialty and divisional quality and safety meetings. These included learning from deaths. The reports seen included details of all national and local audits. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. We saw that action plans were in place to support improvements.

Managers and staff did not use the results from national audits to improve patients' outcomes. The medical division committee meeting and governance meeting minutes did not provide evidence of review and discussion of national audit results.

The service had a lower than expected risk of readmission for elective care than the England average.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a programme of local audit which was reported as part of the monthly integrated performance reports. These included matron quality audits, ward audits and controlled drug audits. Results were reported on a performance dashboard where audit results were rated red, amber or green for compliance. The performance report highlighted key risks and issues across all domains of performance.

The service provided us with a list of 33 clinical specialty audits that had been carried out within the division. Each audit had an associated report or presentation detailing the findings. Governance meetings for the medical division had a standing agenda item of clinical audit feedback and specialty audit findings were presented at these meetings.

Managers used information from the audits with the aim of improving care and treatment but improvements in care were not always able to be demonstrated. The integrated performance reports were discussed at board level and any audit areas of performance concern had associated actions in place. Ward managers displayed copies of performance dashboards on each ward so that staff, patients and visitors could see the audit results. Where there were areas of concern, we saw targeted actions were put in place, for example we saw ward link boards for sharing information on audits and good practise. We saw boards highlighting information around fluid balance, sepsis and dementia. Managers told us that wards with known areas for improvement were being given additional focused and specialised support with additional training and education to improve quality standards. However, performance dashboards from March 2021 to May 2021 showed that areas of amber or red performance, such as nutrition, falls, fluid balance and dementia screening continued to perform poorly and had not improved.

Therapy staff told us that although they recorded some patient outcome measures as part of their assessment, these were not repeated. This was since patients were not seen by therapists for long enough for the opportunity to complete before and after outcome measures. This meant that therapy outcome measures were unable to be used to improve care and treatment.

Managers shared and made sure staff understood information from the audits. There was a monthly Matron and Ward Manager Quality Metrics Assurance Meeting which reviewed compliance with the Nursing Quality Assurance Metrics. This identified areas demonstrating improvement or continued good compliance as well as areas requiring improvement. Managers told us that audit performance information was shared with staff at ward staff meetings (where these happened) and any areas of performance concern were highlighted. However, we found there was little evidence of regular team meetings at ward level and the minutes did not evidence sharing of audit performance information. Audit results were shared at care forum groups. We saw that the Recommended Summary Plan for Emergency Care and

Treatment (ReSPECT) audit findings were shared through a presentation delivered to the renal governance forum. At the neurology care group forum, findings of an audit on inpatient Administration of Parkinson's Disease Medication was presented. Following these presentations, we saw that recommendations were made so that appropriate actions could be implemented.

Improvement was checked and monitored. Although audit performance was monitored through performance dashboards and board reports, there was no evidence of consistent improvement in audit performance.

The endoscopy service was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). The latest submission to JAG had resulted in the service being fully accredited having successfully implemented an action plan to improve.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance. However, supervision meetings were not held consistently with staff to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nursing staff worked together using a skill mix approach to ensure staff had the appropriate skills to provide safe care for patients. Nursing shifts were covered by both registered nurses, nursing associates and health care assistants and were supported by a senior nurse who was in charge of the ward. Newly qualified nursing staff were supported to complete preceptorship training. Preceptorship is a period of time to guide and support all newly qualified practitioners to translate their knowledge into everyday practice and make the transition from students to develop their practice further. Newly qualified nursing staff completed competencies for procedures such as nasogastric feeding, catheter care and intravenous access. Some healthcare assistant staff had been supported to complete the trainee nursing associate programme. All registered nursing staff are required to complete revalidation to renew their professional registration, and we were told that the trust actively supported this process. Overseas nursing staff were supported to complete their objective structured clinical examinations (OSCE) in order to become registered with the Nursing and Midwifery Council (NMC). Staff working on medical specialty wards such as respiratory, cardiology and endocrinology completed competency-based training to develop specialist nursing skills.

Junior doctors received weekly teaching and said there were no issues attending this. They described a good level of teaching from consultant staff. Senior medical staff told us that new junior doctors received teaching sessions when they started in a new department and that regular half day teaching sessions were included in their working rotas as protected time.

Therapy staff were supported by therapy support workers who worked across different therapy disciplines. Support workers completed competencies in order to develop specific skills.

In the endoscopy unit, the unit was closed (except for emergencies) to enable all staff to complete specialist training every four months.

Managers gave most new staff a full induction tailored to their role before they started work. Overseas nursing staff worked supernumerary to planned nurse staffing numbers until they had completed their OSCE. Agency nursing and medical staff we spoke with told us that they had received a tour of the ward / department and completed an induction checklist. However, an agency member of therapy staff we spoke with told us that they had not received any induction and were sent to many different wards to provide cover without any information.

Managers supported most staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they had received appraisals. Data provided by the service demonstrated that 75% of registered nursing staff had received an appraisal in the last year. For additional clinical services staff (healthcare assistants and nursing associates) 76% of staff had received an annual appraisal. In addition, 94% of therapy staff and 97% of medical staff had received an annual appraisal in the last year. This was an overall compliance rate of 85.5%.

Managers could not demonstrate that they supported nursing staff to develop through regular, constructive clinical supervision of their work. There was no system or process for nursing staff to receive any form of regular supervision. However, junior doctors we spoke with told us that they received good supervision from consultants. Junior doctors had nominated clinical supervisors. Therapy staff we spoke with described a regular system of supervision every six to eight weeks, which was documented.

The clinical educators supported the learning and development needs of staff. There were specialist nurses who had a remit to support staff in developing specialist knowledge and skills. This was through advice and support, training sessions and the signing off of specialist competencies. There were specialist nurses in respiratory, dialysis, end of life care, dementia and mental health.

Managers did not make sure staff attended team meetings. However, there was access to meeting notes when staff could not attend. Meetings did not consistently happen at ward level. Nursing staff told us that there no regular team meetings. Managers told us that whilst there had been some team meetings prior to the COVID-19 pandemic, these had not continued in any format. We asked the trust to send minutes of the last two meetings held on each ward in the medicine service, but they could not provide these. We did see evidence of a recent meeting on the renal unit, and another in the endoscopy service, but these were exceptions. Ward level meetings did not routinely happen in the medical care service. We did see some evidence of daily team briefings held on the renal unit where patient safety issues, topics of the day and any trust updates were discussed. Copies of each brief were kept in a folder at the nursing station so staff who had not been on shift could access the information. Therapy staff told us that monthly therapy staff meetings were held which all therapy staff were invited to attend. These meetings were documented and minutes were circulated by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers used the appraisal process to identify any individual staff learning and development needs. On the renal unit there were three staff who were completing the trainee nurse associate programme after identifying this as a learning opportunity in their appraisal. In addition, therapy staff told us they held a programme of regular in-service training sessions to develop staff knowledge and skills. Senior managers told us they were promoting a skills-based approach to working, through joined up educational programmes rather than role specific. They recognised that staff in roles such as advanced care practitioners, doctors and advanced nurse practitioners had similar skills and training needs. All these groups of staff were invited to departmental teaching sessions.

Managers made sure staff received any specialist training for their role. Staff who worked on the respiratory ward completed competencies for the management of patients receiving non-invasive ventilation (NIV). This involved staff receiving training and observed practice in the care of NIV patients. Staff did not have responsibility for NIV patients until their competencies were signed off by a senior member of staff.

Multidisciplinary working

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

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Data showed attendance at weekly multidisciplinary team (MDT) meetings was quorate without palliative care attendance for 85% of the time for lung MDTs from April to June. This meant that a specialist nurse, radiologist, consultant surgeon and oncologist were routinely meeting together to make decisions regarding recommended treatment of individual patients. In addition, we observed that there were daily multidisciplinary board rounds held on each ward. These were attended by nursing, medical and therapy staff with a purpose of sharing up to date information about patients and making shared decisions about their care and treatment plans and discharge planning. We observed that all staff had a voice during these meetings and there was effective discussion as an MDT. Therapy staff explained that although there was pressure to discharge medically fit patients, medical staff respected therapists opinions when they felt patients were not ready for discharge.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships between nursing and therapy staff and we saw that there was a holistic approach to patient care. Therapy staff worked with nursing staff to incorporate rehabilitation into routine ward activities to ensure therapy was purposeful. There was a recognition that therapy resources were limited and that nurses could incorporate a rehabilitative approach into their care based on advice from therapists. Therapy staff worked with community rehabilitation services to coordinate safe discharge and continuation of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There was a mental health liaison team who supported staff to provide appropriate care for patients experiencing mental ill health. Staff were able to contact the team 24 hours a day for specialist assessment of patients with complex mental health needs.

Patients had their care pathway reviewed by relevant consultants. Consultants completed daily ward rounds on all medical care wards. Patients would receive care on medical specialty wards where appropriate in order that they were under the care management of the most appropriate consultant.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were regularly reviewed by consultants depending on the care pathway. However, the trust did not meet the standards within the seven-day services self-assessment tool relating to review. Trust data showed that 75% of patients on an established care pathway saw a consultant at least once a day.

Staff could not call for support from all disciplines, including therapy services, mental health services and diagnostic tests, 24 hours a day, seven days a week. Therapy services were not widely available seven days a week. Most wards had five-day therapy cover, Monday to Friday. Emergency physiotherapy cover was available for respiratory patients in the evenings and at weekends. Managers told us that the frequency of weekend working for physiotherapy staff could be as much as one or two weekends per month. In addition, therapy managers told us that there was a discharge occupational therapist and physiotherapist who worked on a rota to provide weekend cover. Since there was not the capacity in the therapy staffing resource to give staff who worked at weekends time off in the week, this meant that it was difficult to sustain weekend working for therapy services. Despite the national requirement to achieve seven day working, this was not yet in place for therapy staff. A business case was in progress, but this had not been agreed at the time of our inspection. However, the acute medical unit had therapy cover from 8am to 6pm seven days a week. This was to facilitate timely discharge and avoid unnecessary hospital admission as it was a short stay ward with a target length of stay of less than 24 hours.

Pharmacy services were provided to wards from 8am to 6pm Monday to Friday and from 9am to 12 noon on Saturdays. There was an emergency duty pharmacist available 24 hours a day, seven days a week to provide urgent support and advice when required.

Mental health liaison services were available for 24 hour support seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw information display boards and health promotion leaflets on most wards we visited. However, we did not see evidence that staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff did not always document assessment of patients' lifestyles including smoking and alcohol use. We saw that this section of the nursing assessment template was often not completed. We did not see evidence in patient's records that any healthy lifestyle advice was given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, not all staff had completed training in the Mental Capacity Act, Deprivation of Liberty Safeguards and Mental Health Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed mental capacity assessments in patient records where there were concerns over an individual's ability to consent to care and treatment. Staff were able to explain the process for assessing a patients mental capacity. The process was clearly documented in patient's records. For example, we reviewed the records of 14 patients who were under a DoLS application and we saw that in each case a mental capacity assessment and best interests decision had been completed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed nursing and therapy care during our inspection and heard staff asking patients for verbal consent to provide care or treatment, where they were able to provide this. In the endoscopy clinic, there were written consent processes in place and we saw these were followed in line with guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service used a hospital passport document to identify patient's individual wishes. These were completed by the dementia team with the involvement of a patient's relative and provided information about a patient's care preferences. Best interest decision documents were completed where mental capacity assessments indicated patients did not have the capacity to make a particular decision. In the 14 records we reviewed of patients under a DoLS application, we saw that best interest decisions had been recorded in all 14 records. Best interest decisions were made as a MDT and involved the patient's relatives or carers where possible.

Medical care (including older people's care)

Staff made sure patients consented to treatment based on all the information available. We saw that there was an informed consent process in the endoscopy clinic to ensure patients had all the appropriate information about the procedure available before consenting to it. Patients told us that they had been given information about endoscopy procedures and staff had taken time before the procedure to ensure they understood the information. Information provided included the procedure process and any risks associated with the procedure.

Staff clearly recorded consent in most patients' records. We reviewed four patient endoscopy records and saw that consent to the procedure was recorded in all of these. However, staff did not always record verbal consent given for the provision of nursing and therapy care on a day to day basis.

Staff did not all receive or keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service provided data for completion of Mental Capacity Act (MCA), Deprivation of Liberty Safeguarding (DoLS) and Mental Health Act (MHA) training. Average compliance for completion of these training sessions across all staff groups in medicine was 73%. Medical staff had the lowest overall compliance for these training sessions at 44%. However, the service told us that there had been a three month pause on the delivery of this training due to the impact of the COVID-19 pandemic.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff were supported in DoLS applications by the safeguarding lead who visited wards daily. They provided training, advice and support with the DoLS application process and reviewed all applications made. All staff were given a DoLS principles card on completion of training which prompted them when to consider DoLS applications and how to complete these. There was a process where the safeguarding lead reviewed records of DoLS applications made against a list of applications received by the local authority. This meant that the safeguarding lead had oversight of the number of patients in the service under a DoLS at any time.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a trust intranet page which outlined the process for making DoLS applications. The process was detailed in the trust DoLS policy.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Nursing quality metrics were completed monthly. MCA and DoLS documentation was audited. Following the inspection, the service provided us with audits from April 2021 to June 2021 which demonstrated on average the service was 78% compliant with these measures. This was below the trust expected standards.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

Medical care (including older people's care)

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, they did not always respect patient's privacy and dignity.

Staff were generally discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we saw a caring approach from staff. We saw that staff of all grades and roles talked to patients in a friendly and reassuring manner. For example, during an endoscopy procedure we heard staff explaining the process and reassuring the patient. We heard a ward hostess discussing meal choice options with patients and observed them displaying a friendly and helpful approach.

Patients said staff treated them well and with kindness. We did not have opportunity to speak with many patients during our inspection. However, comments from inpatient surveys completed from October 2020 to March 2021 included 'always treated with respect, patience and humour' 'the staff were very helpful and caring. Very professional' and 'nursing staff were very caring and understanding and respectful'. The surveys showed that for the period October to December 2020 97.4% of patients said that staff were caring and compassionate, and 96% of patients said staff treated them with dignity and respect. For the period January to March 2021, 98.1% of patients said that staff were caring and compassionate and 96.6.% of patients said they were treated with dignity and respect.

Staff did not always follow policy to keep patient care and treatment confidential. We observed incidents where we saw patient dignity was not upheld. On two occasions on different wards we saw that patients were left uncovered on the bed. We observed one patient have care provided by staff without the privacy curtains being fully closed, meaning they could be seen by staff and ward visitors.

Staff did not always demonstrate that they understood and respected the individual needs of each patient. The nursing assessment document had an option for completing generic and individualised care plans when risks or care needs were identified. We saw that these were poorly completed. None of the records we reviewed had individual care plans completed for any aspects of nursing care. Staff relied on pre-populated generic risk assessment templates which did not allow for individualisation of care planning. We were not assured that staff were considering the individual needs of patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Chaplain support was available 24 hours a day seven days per week. Holy communion took place every Sunday and this was able to be received on the wards for those patients not able to attend. Prayer facilities were also available for Muslim worshippers.

Emotional support

Staff did not always have time to provide emotional support to patients, families and carers to minimise their distress. However, they understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

Staff were not always able to give patients and those close to them help, emotional support and advice when they needed it. During our inspection we observed that nursing staff were very busy and had little time to interact with patients other than when providing personal care. Nursing staff in bays focused on delivering tasks and care and did not appear to have time to fully engage with patients on the ward. However, data from the latest local inpatient survey (trust wide) showed that most patients felt staff spoke to them appropriately and most staff were caring and compassionate.

Staff supported patients who became distressed in an open environment. We observed staff providing enhanced care support in cohort bays or as one to one care. There was a process for identifying patients who required enhanced care support and wards were usually able to seek additional staffing to support these patients and ensure care was safe. This meant that staff were able to focus care and attention on these patients and meet their needs. We saw one occasion where staff arranged for a confused patient who was agitated to have a television provided to enable them to watch sport. Staff recognised the patient's distress and took action to address this, which resulted in the patient becoming more settled.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Data from the latest quarterly local inpatient survey (trust wide) found that and most patients had confidence and trust in the nurses and doctors treating them and could find someone on the hospital staff to talk to about any worries and fears.

Understanding and involvement of patients and those close to them

Staff did not always appropriately support patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. In the endoscopy clinic we saw that staff took time to explain procedures both before they took place and throughout the procedure. We heard, during board rounds, doctors state they planned to talk to family members to update them on care and discharge plans.

Staff did not always talk with patients, families and carers in a way they could understand, using communication aids where necessary. Where a patient's first language was not English, we were not assured that staff always involved appropriate communication support. We understood that staff had access to interpreting services, however we saw on one ward that staff planned to use another staff member, who spoke the same language, rather than interpreting services, to support communication with a patient whose first language was not English. However, the staff member was not on shift for two days and the only communication tool staff were using was a communication sheet with 12 pictures. This was not sufficient to ensure that staff fully understood the patient's care needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a local quarterly inpatient survey which comprised of 26 questions and a comments section. The survey was sent out on a monthly basis to a randomly selected sample of 1,000 patients, aged 18 or over, who had spent at least one night in hospital during the sample month. The results were compiled on a quarterly basis for the trust as a whole. The data was not specific to medical care wards. The latest trust wide data available for January to March 2021 showed a response rate of 36.3%. In addition, the service participated in the friends and family test (FFT) and displayed the results of these on ward quality boards. On wards we visited we saw the FFT latest data displayed for May 2021. We saw there was a response rate of around 20%.

Medical care (including older people's care)

Staff supported patients to make advanced decisions about their care. We saw Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were completed in patient records where appropriate. The ReSPECT process supports patients to identify their care and treatment wishes for the future in a situation where they may be unable to make or express choices. We saw that these choices were made through conversation between patients, their families, and staff and were recorded on ReSPECT forms stored in patients' medical records.

Staff supported patients to make informed decisions about their care. We saw in the endoscopy clinic that patients were provided with information about procedures, including risks and benefits, before undergoing the procedure. Staff were available to answer any questions they had. This meant they could make informed choices about their treatment.

Patients gave positive feedback about the service. Patient experience data from the quality dashboards showed an average compliance with this quality indicator of 94%, meaning patients felt positively about the care they received. The local quarterly inpatient survey results for January to March 2021 for the trust as a whole were mostly positive, with 72.9% of patients rating their overall experience as eight or higher out of 10.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

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

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

Managers planned and organised services so they met the changing needs of the local population. The service worked with local organisations and the wider system to identify needs of the local population. The frailty service and short stay wards worked closely with community rehabilitation and support services to ensure patients care needs were continued to be met on discharge from hospital. The service operated seven days a week to ensure that patients could be discharged in a timely manner and avoid unnecessary extended length of stays. Senior managers told us there has been a focus on public engagement, aiming to model the best care that the population will need. This work involved the clinical commissioning group to help inform planning of future services. There was work in progress to develop integrated care pathways with community colleagues.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards we visited had single sex bays or side rooms with allocated single sex bathroom facilities. We did not observe any single sex breaches during our inspection. Between April to June 2021 there had been four reported mixed sex breaches in the medicine service. All of these were in the coronary care unit area of ward 24.

Facilities and premises were mostly appropriate for the services being delivered. Wards were designed so that care could be provided in several bedded bays, or in side rooms if there was a need for patients to be treated in isolation. This was with the exception of ward 22 (short stay) where there were no side rooms. Nursing stations were situated in the heart of the ward to enable staff to observe the most vulnerable or unwell patients. However, on ward 22 (short stay) we were told that the environment made it difficult to observe patients as the nurses' station did not have a good view of patient bays. This had been escalated and additional healthcare assistant staff had been allocated to shifts to mitigate the risk.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with acute, complex mental health problems. There was a mental health lead supported by a mental health liaison team who could provide an emergency response when required. There was specialist support for patients with learning disabilities and dementia, but this was not available 24 hours a day. For learning disabilities support there was a contracted liaison service and an inreach service based on the hospital site. The service had access to trust wide dementia specialist nurses were employed by the trust and worked across the hospital site.

The service had systems to help care for patients in need of additional support or specialist intervention. There was an enhanced patient supervision policy which identified the process for identifying patients requiring additional supervision and ensuring appropriate enhanced supervision requirements were met. There were patient boards above beds which used symbols to identify if patients had special care requirements. These symbols were also used on the patient status at a glance board which was located at the ward nursing station. Symbols were used to identify if patients had dementia, were at risk of falls or required support from specialist nurses or therapy staff.

The service relieved pressure on other departments when they could treat patients in a day. The medical care service worked closely with urgent and emergency care, the care coordination centre and the same day emergency care (SDEC) service. There were identified short stay wards and an acute medical unit which supported patient flow. There were regular site meetings involving medical care staff to review and discuss any blockages in the emergency department and how medical care could support these. Medical care reported its bed status at a daily bed management meeting which meant the hospital had oversight of bed capacity. Daily multidisciplinary board round meetings enabled staff to make timely decisions about patient discharge to ensure patients did not have any unnecessary length of stay days.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers. However, staff did not always make reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were specialist teams to support patients with mental health problems, learning disabilities and dementia. These teams visited the medical wards regularly to provide advice and support. The dementia specialist nursing team kept a database of all patients admitted to the hospital with a known diagnosis of dementia. They visited wards where these patients were receiving care to review if their care needs were being met.

The service used a butterfly icon on bedside and patient status at a glance boards to identify any patients with dementia. We saw these used routinely on wards that we visited.

We saw the use of red trays at meal times to indicate which patients needed support with feeding.

Additional resources used for dementia care included the use of activity boxes which included colouring equipment, soft toys, and games, the use of doll therapy, and the availability of electronic tablet devices for reminiscence therapy.

A sensory trolley was in the process of being made available for use by patients with dementia or a learning disability.

Wards were not designed to specifically meet the needs of patients living with dementia. We did not see any environmental adaptations to wards to make them dementia friendly. The use of contrasting colours in bathrooms, clear

signage, handrails, visible large face clocks are all recognised principles of dementia friendly ward designs. We did not see any of these in use on any wards during our inspection. In addition, secure entry and exit systems to the wards were generally not in use during our inspection. This meant patients with dementia who may be confused, were at risk of being able to freely leave the ward.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The dementia team supported staff to identify patients' preferences and interests through completion of hospital passport documents. The team worked with patients and their family to complete a document which provided nursing staff with information to help them meet dementia patients specific care needs. These documents were completed on yellow sheets and stored in Perspex holders by the patients' bedside to ensure they were visible to all staff providing care. We saw two such documents in use on one of the general medical wards we visited.

The service did not have information leaflets available in languages other than English. Staff were not able to tell us if they could access leaflets in other languages that may be spoken by the patients and local community.

Managers did not always make sure staff, patients, or patient's loved ones and carers could get help from interpreters or signers when needed. We saw that staff did not always seek the support of interpreters where necessary. There was a patient who did not receive interpreting support during our inspection as staff were relying on a staff member being able to interpret for the patient when they were on shift. However, interpreting services were available on request.

Patients were given a choice of food and drink to meet their cultural and religious preferences. If the daily food menu did not provide a suitable meal choice, staff told us that a special request could be made to the kitchen for an alternative meal.

Staff had access to communication aids to help patients become partners in their care and treatment. However, the example we saw of one communication sheet used was very basic and was not sufficient to fully support communication around patient care needs.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times but were not always able to make sure patients could access services when needed or receive treatment within agreed timeframes and national targets.

Incomplete Referral to Treatment (RTT) pathways:

As of April 2021, the trust ranked 16th out of the 21 non-specialist acute trusts in the midlands, for the proportion of patients on incomplete pathways that had waited less than 18 weeks. This meant they were not performing well against the requirement to treat patients within 18 weeks of referral for incomplete pathways.

Data provided for the number of incomplete pathways where the patient had been waiting more than 52 weeks, showed the trust had no such waits from November 2019 to February 2020. However, during the pandemic the number increased considerably, reaching 3,295 in April 2021. This had reduced to 2,925 in May 2021 demonstrating that performance was improving.

Medical care (including older people's care)

As of April 2021, the trust ranked 9th out of the 21 non-specialist acute trusts in the midlands for the proportion of patients on completed admitted pathways that had waited less than 18 weeks. This meant the trust was performing similar to the overall midlands and England performance for referral to treatment times for completed admitted pathways.

Complete Referral to Treatment (RTT) pathways:

The number of completed admitted pathways where the patient had been waiting more than 52 weeks for treatment was three, from November 2019 to February 2020. During the pandemic the number increased considerably, reaching 160 in October 2020. In April 2021 the number waiting more than 52 weeks was 154 meaning improvement in reducing wait times for completed admitted pathways was slow.

As of April 2021, the trust ranked 4th out of the 21 non-specialist acute trusts in the Midlands for the proportion of patients on completed non-admitted pathways that had waited less than 18 weeks. This meant that the trust performed better than the overall midlands and England performance for referral to treatment times for completed non-admitted pathways.

The number of completed non-admitted pathways where the patient had been waiting more than 52 weeks for treatment was zero from November 2019 to March 2020. During the pandemic the number increased considerably, reaching 253 in March 2021. By April 2021 this had reduced to 181 demonstrating that performance was improving.

Managers and staff worked to make sure patients did not stay longer than they needed to. From March 2020 to February 2021 the average length of stay across all medical specialties was similar to or lower than expected based on the England average, for both elective and non-elective admissions at both hospital sites in the trust.

The trust had a 'Sath2Home' service which was a domiciliary care bridging service which allowed patients to return home if their care could not be sourced in a timely manner. The service supported the reduction in length of stay (LOS) by facilitating discharge at short notice to ensure patients were discharged in line with national discharge guidelines. Sath2home supported patients who were discharged home where the local authority could not provide care. They also provided bridging support to patients who did not qualify for local authority care support. Managers told us that the impact was a reduced length of stay for complex patients who were medically fit for discharge.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. From November 2020 to May 2021, the percentage of delayed discharges fluctuated over time. As of May 2021, the percentage of delayed discharges across the trust was 55.5%. Compared to other trusts in the Midlands region, the percentage of delayed discharges over time has been better than most trusts. The service monitored stranded (those in hospital more than seven days) and super-stranded (in hospital more than 21 days) patient numbers. The trust provided data for stranded and super-stranded patients within the medical service, although this was not split by hospital site or ward. The data showed that from January to June 2021 there were an average of 290 stranded and 49 super-stranded patients on medical wards. There were weekly LOS meetings that reviewed all stranded and super-stranded patients in the hospital. This enabled staff to work in a targeted way with patients who were not medically optimised for discharge. This included support for the clinicians from the medical directors to unblock or remove barriers and working with system partners to flag patients who required escalation to support their discharge.

Medical care (including older people's care)

The complex discharge team routinely visited medical wards and had conversations with nurses and therapists on each ward to identify any blockages to patient flow. They reviewed the patient status at a glance boards with staff. There were twice daily board rounds on the short stay wards and close working with the emergency department to give a clear picture for the day of admissions and discharges. However, staff told us that patient flow was impacted by the lack of a discharge lounge facility.

The service moved patients only when there was a clear medical reason or in their best interest. Managers told us that they tried to avoid moving patients where possible. However, they recognised that patients were sometimes moved to different wards in order to facilitate patient flow. Managers monitored the number of patient bed moves. Data showed there was an average of 1429 patient ward moves per month on medical care wards from January to June 2021. Ward moves should be limited per admission, but the service did not provide information about average number of ward moves per patient on the medical wards. The service did not provide any information about how ward move data was used to reduce the number of ward moves per patient.

Staff did sometimes move patients between wards at night. Data provided following our inspection showed that there was an average of 392 patient ward moves at night per month on medical care wards from January to June 2021. Night-time moves were moves between the hours of 10pm and 8am. Night moves can be disorientating for elderly and confused patients and should be avoided unless it is essential for the persons care. We saw that as a total of all ward moves, 27.5% of moves happened at night. The service did not provide any information about how night moves data was used to try and reduce the frequency of night moves.

Managers and staff worked to make sure that they started discharge planning as early as possible. The service had a pro-active team work approach to start conversations around discharge planning with complex patients and family before they were medically fit. There were six patient journey facilitator staff employed across the hospital, some of who supported the medical service. They worked from 8am to 4pm Monday to Friday and on Saturdays on a rota basis. Their remit was to support the ward with all aspects relating to the patient journey and discharge. This included transport arrangements, chasing diagnostic test results, to take out (TTO's) medication, chasing patient discharge summaries, and liaising with families, care providers and external stakeholders. They linked in with the integrated discharge team hub to ensure planned discharges happened in a timely manner. We were told that these staff attended daily board rounds and huddles, however, we did not see them in attendance at the board rounds we observed during our inspection. There were integrated health and social care teams on the hospital site which supported discharge planning. Managers told us this improved the timeliness of exchange of information and decision making in relation to discharges through co-location and joined up working.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Junior doctors explained that there was a system for identifying any medical patients who were outliers on non-medical wards. There was a process to ensure outlying medical patients received regular medical review in line with policy and guidance.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. However, the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers did not always know how to complain or raise concerns. The service did not clearly display information about how to raise a concern in all patient areas. Complaints information was not visible in the form of leaflets or posters on some wards we visited. Staff told us that leaflets were available to patients which outlined how to

complain but on one ward when the manager showed us where these should be the leaflet rack was empty. Results from the latest local inpatient quarterly survey (trust wide data) showed that only 13.7% of patients said they saw, or were given, any information explaining how to complain to the hospital about the care they received. However, there was information on the trust website which told patients how they could raise concerns or make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with explained that there was a local resolution approach to any concerns or complaints raised. This was encouraged for any concern that could be dealt with immediately and may be resolved quickly by members of staff who were directly involved in the patient's care. Where local resolution was not possible or appropriate, staff said they would refer the complaint to their immediate manager. All written complaints received by staff had to be forwarded to the trust complaints department.

Managers investigated complaints and identified themes. Managers explained that they were responsible for investigating complaints relevant to their clinical area. All complaint responses were collated by the complaints department and numbers of complaints and any themes were detailed in the patient and liaison service (PALS), complaints and patient experience quarterly reports. The latest report provided which was for January to March 2021 showed that the trust received a total of 183 complaints, which equated to 0.89 in every 1000 patients complaining. Of the 121 complaints closed during quarter four, 20% (24) were not upheld, 55% (67) were partly upheld and 25% (30) were fully upheld. There were 114 complaints in progress in the medicine and emergency division identified in the quarterly report. Of these, 71 were cases where the final response was overdue. Key themes included staff values and behaviours, patient care, communication, admission and discharge and clinical treatment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The process for investigating complaints was set out in the trust complaints policy. Investigating managers were required to review patient's health records and any information obtained from statements or interviews conducted with staff. The manager then was expected to identify actions and learning arising from the complaint and produce a written response within the expected deadline. The response period for complaints varied from 30 to 60 days and depended on the complexity of the complaint and level of investigation required. We saw copies of recent complaint investigations and patient responses that the service had completed which were comprehensive and in line with the policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. The quarterly PALS, complaints and patient experience reports identified any learning from complaints investigations and actions that had been taken as a result. The report also included patient stories which provided insight of personal experiences of care within the trust. Managers told us the stories were powerful tools which could help to improve understanding and learning. Managers told us that complaints were discussed at daily safety huddles and in team meetings, where these happened. This provided further opportunity for learning.

Staff could give examples of how they used patient feedback to improve daily practice. We saw that there were ward display boards which highlighted any learning from complaints and actions taken to make improvement. Ward managers produced and shared synopsis episode of care documents relating to complaints received. These were discussed at safety huddles and identified what went well and areas for learning and improvement.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

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

Leadership

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

The medical care core service sat within the Medicine and Emergency Care division. The division was strategically led by a triumvirate made up of a Divisional Medical Director, Divisional Director of Operations and Divisional Director of Nursing, and centre managers. The triumvirate told us they worked well together and had received positive feedback from staff about their visibility and approachability. They said staff knew who the triumvirate were and that they could raise concerns to them. The triumvirate team held divisional meetings to get communications across to teams and listen to what staff want from them as a leadership team. They told us staff could speak honestly with them and be heard. There was transparency in their approach. When we spoke with staff on wards there was a mixed response to questions about the visibility of the senior leadership team. Whilst some managers said they were aware of who they were and felt they were visible, some ward staff reported that they had no knowledge of who the senior team were or what they looked like.

Local leadership was provided by matrons and ward managers. Staff told us that their ward managers were supportive and that they saw their matron most days. Matrons were visible, supportive, and approachable. There were quality matrons with specific portfolios such as safeguarding and falls who supported the matron team. The quality matrons visited the wards daily and worked with matrons and ward managers on any identified areas for improvement. They described a consistent single team approach where staff felt empowered to talk to matrons and escalate concerns. There were weekly matron meetings to share improvements and issues of concern. The matrons were given the opportunity to enhance their leadership skills through a leadership programme offering leadership master classes. All matrons were invited to regional and national forum groups where they had the opportunity to talk about leadership.

The divisional leadership team had focused on developing matrons and ward managers competence. The senior team provided guidance to support matrons skills and confidence to review incident investigations. In turn ward managers were supported to develop skills in identifying incident themes and action planning with more confidence than before.

There were lead nurses for mental health, dementia and safeguarding who provided trust wide guidance and direction on their specialist area. They promoted the implementation of best practice and provided specialist advice. Staff knew about the specialist lead nurse roles and told us these staff were accessible and acted as a useful resource.

Vision and Strategy

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

The division had a vision ‘to provide excellent care for the communities we serve’ and this was aligned to the trust values and behaviours of Partnering- Ambitious -Caring- Trusted (PACT). There was a medicine and emergency divisional, strategy, people plan and behaviour framework. The document set out a strategy with eight pillars and identified the priority areas and next steps in achieving these. A people promise set out outcomes, priorities and principles for supporting staff to enable safe patient care. There was a recognition that effective communication was vital to help drive change within an organisation and build a desirable reputation. This resulted in a divisional

communication plan aimed at making sustained changes, building trust and understanding. The plan was designed to share key messages with staff and give them opportunity to provide feedback. The strategy identified a range of quality metrics and a milestone action plan to measure success of achievement of strategy. Progress against these were reviewed at monthly meetings.

The strategy fed into the overall trust strategy which was developed through a multi-faceted process including staff engagement, needs analysis and external inputs (such as national guidance, local population health inequalities and the local integrated care system). The trust strategy was sent out for public and stakeholder engagement once a draft version had been approved.

At a ward level there were specific visions and achievements displayed which had been developed by staff on the wards. Each ward had a board displaying successes, aspirations, learning and pride and joy. Managers told us that the aspirations were agreed as a team based on current ward issues and desired areas for improvement or achievement.

Culture

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

Staff told us they felt supported, respected and valued by their ward managers and matrons. Managers told us there had been investment in staff wellbeing and development and that staff wellbeing and morale was one of their top priorities. They gave an example of the 'catch a breath' trust campaign which recognized the need to create safe and calm spaces for staff to have a break. This provision had a positive impact on staff wellbeing. Managers said they do not wait for the staff survey to find out what staff think. They actively go to staff areas and ask how they are feeling and what the issues are for them.

There was a range of wellbeing support available to staff through human resources, such as the trauma risk management (TRIM) helpline, suicide bereavement and the staff wellbeing psychological hub.

Junior doctors told us there was a focus on wellbeing and that they received wellbeing support. Consultants were available, approachable and supportive and invested time in teaching and developing junior doctors.

International nurses said that they had been well supported during their transition to working in the UK. All grades of staff had been helpful and welcoming, and they had not experienced any racial discrimination. There was an international nurse lead and they worked alongside the trust freedom to speak up guardian and assigned nurse ambassadors to support new international nurses.

There was a culture of team working where all grades and disciplines of staff were respected. Therapy staff, nursing staff and medical staff all worked well together with a holistic approach to patient care.

Some therapy staff told us they felt demoralised as the staffing levels impacted on the amount of time they could spend with patients. They felt they were not always able to see all appropriate patients or do a good job. Middle managers for therapy services were visible and supportive but senior therapy managers were not regularly seen as they were based at the Telford hospital site.

We reviewed the 2020 NHS staff survey results for the medicine and emergency division. The service performed below the national average for five areas: health and wellbeing, quality of care, safe environment (bullying and harassment),

staff engagement and teamwork. There was an improvement action plan based on the staff survey results which had been presented to staff. The service did not provide evidence of its progress in achieving the actions highlighted in the plan. The triumvirate were focused on investing in the workforce and addressing behaviours to shift the culture. A behavioural framework has been developed by consulting all staff groups. The framework formed part of the divisional strategy and held people to account. Managers said the framework empowered teams to have a voice and influence change. They recognised that there was still work to do to embed and sustain changes in culture.

The service had an open culture where patients, their families and staff could raise concerns without fear.Most staff felt able to report concerns to their managers, but they also had the option of the freedom to speak up guardian (FTSUG) route. From April to June 2021 there had been 95 concerns raised with the FTSUG across the trust. 45 of these had related to behaviour, which double the number of the previous quarter. A contributing factor for the increase was that the FTSUG had done drop-in sessions for teams which had raised staff awareness. Various actions had been taken to address these concerns including escalation, involvement of human resources, mediation, values and behaviours workshops and roll out of a trust wide cultural programme 'Making a Difference Together'.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us there were opportunities for progression including taking on lead roles, leadership training and opportunities such as the nurse associate programme.

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, not all ward staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance frameworks in place to provide oversight of quality and safety performance, however, we were not assured they were sufficiently robust in consistently maintaining standards. Nursing quality audits were completed monthly and the findings were discussed at weekly meetings between matrons and ward managers. Quality performance issues were raised, and the quality matrons worked with ward managers to identify actions for improvement. We found that there was consistently poor performance in some nursing quality metrics which had not improved despite the agreed actions. Matrons told us they were aware of issues with completion of fluid balance charts and had done a piece of work to raise awareness and target improvement of this. However, during our inspection we found poor compliance with completion of fluid balance charts. Quality and safety performance data was routinely reported to the board through divisional governance meetings. Although there were systems in place to collect, monitor and report quality and safety performance, these were not always effective.

There were clear systems for reporting, investigating and learning from incidents.

Clinical and divisional leaders attended monthly divisional meetings where senior managers discussed performance, quality, risk, governance and human resources. Arrangements supported the cascading of information from board to ward level. The medicine and emergency care division committee meeting took place monthly and was attended by senior divisional leaders. Information was cascaded through divisional matron and ward manager meetings, medicine safety huddles and ward meetings and daily ward safety huddles. During our inspection we found that ward meetings were irregular and, in most areas, had not happened for some time. However, we saw that daily ward safety huddles were commonplace and were an opportunity for sharing board level information with ward staff. We were not assured that all staff received relevant information in a consistent and timely manner.

Speciality governance meetings took place and we saw these were well attended. These covered performance, quality and mortality reviews. We saw there were processes in place to align these to divisional meetings.

Mortality and morbidity meetings took place and fed up to divisional meetings. These meetings were well attended by a wide range of clinical and operational staff and followed a set agenda.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate all relevant risks and issues nor identify actions to reduce their impact. There was no evidence that staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, the service had plans to cope with unexpected events.

The service provided the medicine division risk register which identified three divisional risks. One around the suitability of ward kitchen facilities was red RAG rated and two others were amber RAG rated; one around the impact of kitchen refurbishment and one around staff room facilities. When we asked senior managers about their top risks in the division, they told us these were around medical and nursing staffing and staff skill mix and competence. However, this was not identified on the divisional risk register provided to us. We did see reference to other risks in the minutes of a divisional committee meeting, but these were not listed on the risk register document provided to us following our inspection. Divisional committee meeting minutes showed that risk was discussed as a standing agenda item. In February 2021 minutes stated that no new risks had been added to the risk register as there was no operational risk group. However, managers told us the division met bi-monthly to review the risk register and update it with actions and mitigations. However, these meetings were not minuted. Managers also told us risks were reviewed at a divisional operational group quarterly for oversight, but no evidence of this was provided. Minutes for the divisional committee meeting in March 2021 detailed a review of existing risks with a score of 15 and above. In April 2021 the minutes stated there were no new risks but there was no review of existing risk. Minutes of a ward managers and divisional matrons meeting did not evidence any review or discussion of risk. We were not assured that divisional review and oversight of risk processes were effective.

Managers recognised staffing was the major risk to the service and the hospital as a whole. There were recruitment and retention initiatives in place to attempt to mitigate the risk. Overseas recruitment, close working with the deanery and securing additional finances had all proved successful. However, it was recognised that shortages were still seen in key roles and there was reliance on agency staff.

The service had a nursing and quality performance dashboard which included outcomes from audits, patient safety outcomes, infection prevention and control compliance, medicines management audit, training and staffing data. This was used by the division to monitor performance. Managers told us they had regular meetings with their matrons and divisional director of nursing to discuss ward performance and set actions for improvement. This data was incorporated into the integrated performance report which went to the trust board and quality and safety board. We saw ward individual performance was displayed on most wards we visited. However, we did not see evidence of monitoring of improvement plans in relation to patient outcomes in divisional governance and committee meetings. We saw specialities reported into these meetings, however, did not provide updates on quality performance. There was no process for monitoring progress with any action plans for improved performance.

Performance in national audit outcomes was not integrated into the governance structures. There was no evidence of discussion of actions to address performance concerns in divisional governance or committee meeting minutes.

We were not assured there was effective oversight of the performance of local and national audit or that improvement action plans were regularly reviewed, and their progress monitored.

Although matrons and senior managers told us that staff could talk to them and escalate concerns, had a voice and felt empowered, we did not see evidence that staff were able to actively contribute to decision making about service delivery.

There were business continuity plans in place to maintain delivery of services in the event of planned or unplanned closure.

Information Management

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

Information technology systems were used to monitor delivery and outcomes of patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finance. Access to all electronic systems was secure and required password access.

There was an electronic system that recorded patients observations and allowed nursing staff to monitor change over time. This data was automatically uploaded to the electronic performance dashboard system. All safety and quality audit performance was recorded on the electronic performance dashboard which ward managers had access to. Performance outcomes were RAG rated to identify areas of compliance and concern. Managers could see their own ward performance information as well as that of other wards so it could be compared. The dashboard tracked performance over time and enabled staff to identify any areas of worsening performance.

The trust shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Engagement

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

Most staff and managers we spoke with said there had been opportunities to feedback to senior managers and trust wide managers. Managers held drop-in sessions for engagement so that staff felt listened to and able to raise concerns. Freedom to speak up guardians had offered drop-in sessions to increase opportunities for engagement with staff. Examples of actions taken following engagement were plans to improve staff break areas and putting air conditioning in place in specific areas to improve staff wellbeing.

The freedom to speak up guardian reports to the board demonstrated that staff were speaking up, including junior doctors, therapy staff and nursing staff.

Managers used the values and behaviour framework to engage with staff. Staff had opportunity to contribute to the framework and identify acceptable and unacceptable behaviours.

Most staff told us they felt engaged with by the service managers.

Patient feedback was collected and used to shape services. The service used the friends and family test (FFT) feedback, local inpatient surveys, 'gather' (matron and senior nurse weekend checks) and exemplar feedback to gather information on patient experience of the services the hospital provided. In addition, patients could provide feedback through the feedback hub on the trust website through submitting a feedback form, sharing their story (through text, audio and video options), completing an FFT survey online, through completing a survey, or raising a concern or sharing feedback. There was a patient experience team who produced quarterly reports that collated all patient feedback along with any themes from complaints and compliments. The report was presented to board and widely shared with staff across the trust. It identified learning and any actions required from the feedback. Priorities for next steps to improve patient experience were also highlighted.

There was a patient and carer experience panel which consisted of public and staff representatives who worked together in a collaborative approach towards quality improvement and patient experience within the Trust.

The patient experience team worked closely with other local providers and charitable organisations to implement improvements for patient experience.

The trust engaged with key stake holders through attendance at council meetings in the development of their operational plans and local strategic initiatives. There was regular engagement with the local clinical commissioning group to review the service delivery to ensure it was satisfactory and met the needs of the local population.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, there were areas identified for improvement at our last inspection which were still of concern.

All staff we spoke to were committed to making improvements. The service leaders as a team were in their infancy but recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service. Leaders engaged staff when making improvements.

During our inspection we found there were some improvements since our previous inspections in 2019 and 2020. For example, staff felt more supported by senior management. There were improvements in the completion and quality of mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards. There was more focus on supporting patients living with mental ill health and dementia and specialist roles had been developed to support staff in managing patients living with these conditions. However, we found there were continued breaches consistent with findings in previous inspections. For example, there were continued concerns around individualised care planning, completion of fluid balance charts, and completion of risk assessments such as nutrition and falls. Whilst we saw some improvements had been made in some areas within the service, the pace at which the improvements were being made was slow and areas of required improvements were not consistently addressed. This raised concerns of on-going risk of harm to patients.

End of life care

Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training.

Mandatory training was largely delivered through the online learning portal but was not comprehensive to meet the needs of patients and staff. The trust mandatory training target was 90% but not all staff groups within end of life and palliative care met this target. Overall compliance for the team was 84%. Mandatory training requirements were different for the various members of the team. For example, the mortuary staff were not required to undertake infection prevention and control training. We requested further clarification from the trust but did not receive it. Data submitted by the trust showed palliative care doctors had not completed updated training for two out of the eight mandatory modules, which included fire safety and equality and diversity. Overall compliance was 75%.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Bereavement and chaplain staff did not receive Mental Capacity Act, Deprivation of Liberty and Mental Health Act training. This had the potential to affect patient care and lead to serious safety risks amongst the bereavement and chaplaincy services.

Safeguarding

Staff understood how to protect patients from abuse, however they did not always have training on how to recognise and report abuse or how to apply it.

Staff did not receive training appropriate to their role on how to recognise and report abuse.

The intercollegiate document 'Adult Safeguarding Roles and Competencies for Health Care Staff' 2019, states that all practitioners who have regular contact with patients, their families, carers or the public should complete level 2 Safeguarding Adults training.

The trust target was 90% for Safeguarding Adults level 2, but not all staff groups met this target for their mandatory training. Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training requirements were different for the various members of the team. At the time of our inspection data showed palliative care doctors had not had update training for safeguarding children level 2, PREVENT level 1 and had not completed PREVENT level 3. The bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

End of life care

The intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Health care staff' 2019 states all non-clinical and clinical staff who have any contact (however small) with children, young people and / or parents/ careers or any adult who may pose a risk to children should complete level 2 safeguard children training. This had the potential to affect patient care and pose serious risks to patients due to staff not being able to recognise safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns but were unable to describe recent safeguarding referrals or any subsequent learning following them.

Cleanliness, infection control and hygiene

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

Ward areas we visited, and the mortuary were visibly clean and had suitable furnishings which were clean and well-maintained. However, staff did not always follow infection control principles. Staff were aware of current infection prevention and control guidelines, including the process for screening patients for COVID-19, MRSA and Clostridium Difficile, prior to and during an admission to wards. Staff observed social distancing where this was possible and wore appropriate PPE. There were handwashing facilities and PPE stations on wards we visited, which were well stocked and included information on PPE requirements.

Most cleaning records were up-to-date and demonstrated that most areas were cleaned regularly. However, cleaning records for the mortuary were not fit for purpose as they showed only signatures of the staff whom had carried out the cleaning. Staff were not able to describe effective cleaning processes and were not able to articulate deep cleaning requirements for these high-risk areas. There were no policies or procedures to outline the cleaning requirements for the mortuary. This posed a significant risk of infection spreading to the immediate mortuary staff and throughout the hospital.

Inspectors raised these concerns immediately with the trust and the provider developed a draft cleaning process following inspection.

Environment and equipment

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

The mortuary had an additional designated external entrance, set in landscaped gardens and would be accessed by families and loved ones. This entrance was effectively designed and bright and airy. The mortuary had capacity for 96 patients, which included four freezer spaces and nine bariatric body stores.

Transport and security measures in relation to the mortuary were effective. Patients were transported to the mortuary by porters and all staff accessing the mortuary were required to log entry at all hours of the day and night. Records were up to date and completed

appropriately. Thermostatic temperature checks for all of the refrigerated body stores checks were monitored electronically and linked to a central alarm system should one of the fridges detect a significant change in temperature.

End of life care

The service had suitable facilities to meet the needs of patients' families. However, side rooms were limited on the wards and demand for these rooms was high when dealing with infection control issues. The hospital had several SWAN rooms which were specifically developed and designed rooms to support patients receiving end of life care. The Royal Shrewsbury Hospital had 14 SWAN rooms, one of which was unavailable at the time of inspection due to maintenance issues.

End of life resource boxes which were designed and provided by the end of life team, were available on all wards we visited. These boxes had recently been introduced to assist ward staff with advice and support across all areas of palliative and end of life care.

The service had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. Staff explained there were occasional difficulties obtaining the syringe drivers, but the availability had generally improved.

'Grab and go' boxes were introduced across all wards which contained relevant equipment to make up two syringe drivers.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks, however risk assessments were not always reviewed regularly. Staff did not always identify and act upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risks assessments for each patient were completed upon admission but some assessments were not reviewed consistently.

Specialist palliative care nurses and end of life nurses were accessed through separate referral processes. Ward staff were required to make a manual telephone referral as the trust did not operate an electronic system. Risks were not routinely requested or reviewed at this stage.

Some end of life patients were identified through the electronic system, as they had been assessed as requiring 'no observations'. This meant patients were often at the very end stage of their lives before they would be known to the palliative and end of life teams.

The service's application and use of ReSPECT forms still needed to improve. A trust wide audit of the use of ReSPECT forms was carried out in May 2021 and signed off in August 2021. It showed personal preferences were only completed 80% of the time but 59% of these did not have capacity, so it should not have been completed. It also showed evidence of a ReSPECT discussion was only present in 64% of patient notes. The audit also highlighted only 53% of patients had any involvement in the making of their plan and only 42% was discussed with others when the patient themselves did not have capacity.

The criteria for referral to the end of life team was the patient was deemed to be in the last 72hrs of life. There was no oversight across the whole of the hospital of all end of life or palliative patients, this posed a significant risk that individuals requiring intervention, did not receive it.

End of life care

The service had still not established an effective system to ensure the identification of all patients who were at the end of life. Following inspection, the provider developed an action plan which included plans to address this.

Most staff shared key information to keep patients safe when handing over their care to others. However, during shift changes and handovers staff did not include all of the key information to keep patients safe.

The specialist palliative care and end of life teams carried out a 'huddle' each morning to identify which patients were to be seen within the hospital. Specialist palliative care staff explained they did not use a clinical triage system to determine patient prioritisation or acuity. Basic information such as the name of the patient, reason for the referral and the name of the member of staff, whom was making the referral, was recorded. In the absence of a clinical triage process there was a potential risk to patients, who were at greatest need or at the highest risk, may not be prioritised effectively. Staff explained they would always try and see everyone, but this decision was not made on clinical need.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team. These teams worked across both the Royal Shrewsbury Hospital and Princess Royal Hospital sites.

The end of life care team consisted of a whole time equivalent (WTE) band 7 end of life care facilitator and three band 6 end of life care specialist nurses. These nurses equated to the equivalent of 1.8 (WTE) staff and provided end of life cover across sites from 8.30am to 4.30pm. No cover was provided on Friday afternoons.

An administrative assistant provided WTE 0.8 band 3 support. There were no vacancies within the end of life team at the time of inspection.

Nursing staffing levels still did not meet the minimum standard of the National Institute of Health and Care Excellence (NICE). These standards state access to specialist palliative care should be made available seven days per week. The specialist palliative care team consisted of six WTE band 7 clinical nurse specialists (CNS), two of whom has been recruited recently. The six nurses worked across both sites and provided a service Monday to Friday 8.00am – 6.00pm and staffing was adjusted throughout the week to meet the needs of the patients across both sites. Out of hours cover, including weekend cover, was provided through an on-call service at a local hospice.

Staff explained that plans were in place to offer specialist palliative nurse cover, seven days per week from September 2021. This would include a palliative care team leader who would manage the specialist palliative care nurses and the end of life care team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust employed 0.9 WTE palliative consultant who provided cover to both the Royal Shrewsbury Hospital and the Princess Royal Hospital sites, Monday to Friday. The cover was provided on site for four days of the week and one day remotely.

In addition, one palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.4 WTE cover to the trust. However, this position was a fixed term contract which was due to end in July 2021. There were no arrangements in place to provide ongoing cover after this time.

Improvements in respect of consultant cover had been made but medical staffing levels still did not meet the minimum standard of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. Cover had been increased from 0.8 WTE to 1.3 WTE despite difficulties in recruiting. The trust had secured a budgetary increase to 3 WTE which they were currently recruiting too, however there was a shortage nationally.

Medical staffing recruitment was an ongoing challenge for the trust and several attempts to fill an additional substantive palliative care consultant post had been unsuccessful.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, and up-to-date. However, records were stored securely and easily available to all staff providing care.

The trust utilised paper-based records for assessment and care planning with vital observations such as blood pressure monitoring, oxygen saturation and pulse recordings logged electronically.

Patients receiving end of life care were commenced on the 'Caring for adults in the last few hours and days of life' care plan. However, as patients were not identified as requiring end of life care until 72hrs prior to death, this documentation was not completed prior this point.

We reviewed trust guidance provided to staff to support them with the completion of the 'Care of the dying care plan' document and saw that guidance did not define appropriate timescales for the necessary completion of the document. This resulted in the care plans being incomplete which potentially impacted on the safe care and treatment patients received. We saw two examples of the original version of the care plan in use, however the document had not been fully completed. In addition, recommended summary plans for emergency care and treatment patients (ReSPECT) plans were not in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment. A new updated version of this care plan was to be piloted at The Princess Royal Hospital, at the time of inspection.

The trust had not made improvements to ensure staff had access to the information they needed to provide person centred care. Patient records did not include a complete and accurate record that described patients' individual needs and preferences.

We saw patients receiving specialist palliative care support, who did not have bespoke documentation and any intervention provided by the team was recorded within the patient's medical records, which posed a risk that this documentation would be missed.

We did see evidence of patients preferred place of care and do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients' notes and completed capacity and consent records in both records.

Records were located at the nurse's station and were stored securely.

End of life care

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always provided in a timely manner.

Staff followed systems and processes when safely prescribing, recording and storing medicines. A pharmacist visited wards Monday to Friday to review prescribing of medicines including palliative care and end of life care prescribing. The pharmacy team checked patient's medicines to ensure they were prescribed correctly, any discrepancies were identified and highlight to the relevant teams.

There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours.

Prescribing guidelines for anticipatory end of life care were available on the trust intranet. This included information on the medicines available and information on prescribing.

Anticipatory end of life medicines were available on all wards visited.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patient's allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Patients' weights were documented on all the medicine records reviewed.

Pharmacists checked that prescribed medicines were compatible when syringe drivers were used.

Pharmacy provided counselling and support to patients and carers to explain changes in medicines or when new medicines were started and allow them to raise concerns and ask questions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. However, we saw delays in patients receiving prescribed analgesia.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

Incidents

The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers shared lessons learned with the whole team and the wider service.

End of life care

At the last inspection in June 2020 the trust were told they must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. We requested the last ten incidents which were reported under end of life or palliative care and we saw there were themes associated with a delay in verifying death, the environment in which end of life was delivered and medicines management, with the remaining incidents varying in theme.

Staff knew what incidents to report and how to report them. We reviewed an incident on ward 28 relating to care of the deceased. Staff explained how the incident was investigated swiftly, and action taken to mitigate further incident. Staff were encouraged to reflect on the events of the incident and share learning across the ward.

We reviewed the minutes of the last end of life steering group meeting and saw that incidents were regularly discussed and reviewed.

We saw evidence of shared learning on most of the wards we visited and actions were taken by the hospital to improve services. However, not all staff, we spoke with, delivering end of life or palliative care were unable to identify incidents that had recently occurred within the speciality and we did not see any overarching trust action plans to address themes emerging across the speciality. For example, care of the deceased.

Is the service effective?

Inadequate  

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

The trust developed the 'Caring for adults in the last few hours and days of life' care plan, which was developed for patients who were entering the last days of life and was designed to address the holistic needs of the dying person by providing supportive and compassionate person-centred care. The document introduced in 2014 by the trust, replaced the Liverpool Care Pathway document. Plans were in place to roll out an updated version of the care plan, but staff explained that the original version was the only document in use at the time of inspection, whilst staff awaited training.

Staff followed up-to-date policies to plan and deliver high quality care. However, this did not always follow best practice and national guidance. Patients were commenced on the care of the dying care plan, when they were assessed as 'end of life' or meeting the 72hr criteria for end of life care. However, the service was not following best practice, for example, the General Medical Council (GMC) states that end of life patients are those identified as likely to die in the next 12 months.

The trust's last audit of the care of the dying care plan was October 2020, and results were mixed. In some areas of the document, such as evidence of conversation between the patient and the medical team responsible for their care was 33% and evidence of consultant involvement was 53%. However, evidence of conversation between patients' relatives and staff scored 100% and in June 2020 it was recorded that all twelve patients receiving end of life care were found to have the care plan in place. In the same audit 92% of patients had a recorded ReSPECT document in place.

End of life care

Ward staff delivering end of life and specialist palliative care, told us they were able to access policies on the trust intranet. The end of life team had a dedicated website offering symptom guidance, referral pathways and general advice, which reflected national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that were available when required.

The trust did not have oversight of all patients requiring end of life or palliative care within the hospital. There was currently no electronic palliative care co-ordination system (EPaCCS) in place. The trust utilised an electronic ward review system, but it did not incorporate any software for alerts or co-ordination of palliative care or EOL patients.

The service still did not have an effective system to identify where patients at the end of life were, throughout the hospital.

The most recent visit to mortuary services by the Human Tissue Authority (HTA) in 2016 concluded that despite some minor shortfalls, several strengths were identified. The associated action plan to rectify the one shortfall provided by the trust was appropriate and set reasonable targets for completion.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed staff followed MUST scoring for nutrition and hydration appropriately.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw records within the generic nursing notes which recorded nutritional needs and evidence of nutritionist involvement. However, nutrition and hydration needs could not be recorded using the care of the dying care plan as the section related only to artificial hydration and nutrition. Staff explained that pain assessments could be improved as occasionally referral to dieticians was delayed.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, the risks and benefits of hydration options, were discussed with families and others in 10% of cases, compared to 35% nationally. For 72% of patients, no reason for not discussing this was recorded. This was worse than the national proportion of 49%. The risks and benefits of nutrition options were not discussed with families and others for any cases. Nationally the figure was 28%.

We saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care. Staff explained that the end of life team were supporting ward staff with additional mouthcare training.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.

End of life care

We saw pain assessments were inconsistently documented for palliative and end of life care patients across some wards we visited. We saw varying pain assessment tools available to clinical staff. Upon review of three patient records, we saw only one completed pain assessment tool. All the patients we reviewed had experienced pain or discomfort and had been prescribed analgesia. We found that pain assessments were not reflective of the patient's current pain levels and had not been updated. This had the potential to affect patient care and pose serious risks to patients due to the lack of staff intervention through regular assessment.

The care of the dying care plan did not support individualised care planning regarding pain management and did incorporate a pain scoring tool. Tick box prompts were used if a patient was experiencing pain with a limited amount of space in the document to record evaluation.

Patients did not always receive pain relief, soon after requesting it. We visited two patients, currently receiving end of life or palliative care, and found both patients in pain. One patient had been waiting for a replacement syringe pump to be commenced and family told us they had chased this with staff three times before action was taken. We reviewed medication records which corroborated the delay in administering analgesia through the syringe pump. Family explained this had happened on more than one occasion. Another patient was found to have had a bladder washout, but staff had not emptied this in accordance with clinical guidance causing severe pain and distress. Inspectors brought this to the attention of staff, who took immediate action.

Anticipatory end of life medicines were available to all wards we visited.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, anticipatory medicines for symptoms likely to occur in the last days of life were prescribed and administered in 34% of cases, compared to 68% nationally.

The service was not undertaking specific audits for pain or symptom management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service did not have an end of life care dashboard to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level. However, leaders explained that there were plans in place to implement both elements.

The end of life and specialist palliative care teams' input was monitored using forms, completed by the team, detailing how their patient was referred and what their input was. However, these documents did not monitor how comprehensive the team's record keeping was, nor the effectiveness of their care in influencing outcomes for patients. The trust did not have a policy or process to define this, to ensure consistency of recording.

Managers and staff carried out a programme of audits to check improvement over time. We requested details of all audits relevant to end of life care, which were undertaken. We received audit details relating to the October 2020 National Care Audit of Care at The End of Life of (NACEL), Care after Death Audit, SWAN Room audits, Care of the

End of life care

Deceased mortuary audit, bereavement survey results, the End of Life Care Plan Audit February 2021, mouthcare and an audit of the Swan “Grab and go T34 syringe driver policy. The mouth care audit (which included all patients not just end of life patients) was dated September 2020, showed 41% of staff were not aware of the mouth care policy and 52% of staff stated they had used a mouth care chart.

Managers and staff did not use the results of these audits, to improve patients' outcomes and we did not see an action plan to address these findings.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

The trust included end of life as part of mandatory training for all staff. The trust provided training figures for end of life training with compliance being 81% as of July 2021.

The service did not have a clinical educator role, however, the team delivered and oversaw a programme training relevant to end of life and palliative care. Also, the End of Life team offered bespoke training sessions to ward staff when requested. Ward staff explained that these sessions had been beneficial, but there was no formal review of training, to show how this had potentially improved patient care. They did not monitor where and when training had been delivered.

Wards were provided with an end of life resource file which included guidance in symptom management, referral pathways, useful contact numbers and care planning information.

At the last inspection in June 2020, the trust were told they must ensure staff were competent in their roles. This included but was not limited to the use and the completion of ReSPECT forms and the use of syringe pumps. Syringe driver compliance figures supplied by the trust demonstrated compliance at the hospital was 91%.

We told the trust in August 2020, that improvements must be made to ensure that staff were competent in the use of syringe pumps when required. Syringe drivers were used in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010 and had checklists to ensure they were used appropriately. However, we reviewed two copies of syringe driver documentation and saw that these checks were not completed in accordance with the trust standard operating procedure; ‘Grab and go Box for T34 Syringe pumps’. The guidance states that the cannula should be checked every four hours, but records showed checks were carried out between five and six hourly intervals. The trust did not audit syringe driver documentation.

End of life champions were available on some of the wards, but we did not see any evidence of cross-directorate working to share learning and best practice. For example, performing last offices, which is the term given to the care after death.

Specific counselling training was provided to some staff in the bereavement team. One of the bereavement staff explained they had completed a ‘Sage and Thyme’ which is a counselling course and is supportive of staff working within bereavement services. But this did not appear to be routinely offered to all staff.

Managers gave all new staff a full induction tailored to their role, before they started work. We saw two newly seconded specialist palliative care nurses supported by mentors as part of their induction.

End of life care

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance rates for the end of life and specialist palliative care team was 100%. However, none of the specialist palliative care nurses received clinical peer supervision or received regular clinical competency training reviews.

Managers made sure staff attended team meetings and provided access to full notes when they could not attend. End of life steering group minutes were distributed to the team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Systems did not support effective communication between multi-disciplinary teams. For example, specialist palliative care nurses received ward referrals by telephone, patients admitted to the hospital by the hospice were referred electronically and GP (General Practitioners) referrals were submitted through the electronic hospital database. All processes were independent of one another and none of the end of life staff had oversight of all the patients requiring potential support in the hospital. However, end of life and specialist palliative care teams met each morning virtually, to review referrals Monday to Friday.

Clinical outcomes were not clearly documented, clinical triage was not in place and effective collaborative team working was not measurable due to the lack of clinical care planning. For example, the patients we saw experiencing pain and discomfort were known to and had been visited by the specialist teams

Ward staff explained that fast track and end of life discharges were managed by the complex care team. However, none of the staff we spoke with were able to outline the last end of life patients whom were discharged by the complex care team. Data provided by the trust showed, from August 2020 to June 2021, 293 patients were discharged via the complex discharge team at the hospital.

All ward staff we spoke with told us that end of life and specialist palliative care colleagues were visible on the wards and we saw staff working together to share information.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, end of life steering group meetings were not consistently attended by all members of staff. Specialist palliative care nurses explained that they required a laptop to access the meetings and this was not always available.

Mortuary staff were not included in these meetings and explained that they had offered training to support ward staff to undertake last offices, but the training was not implemented.

A local hospice provided out of hours advice and support to staff and patients, however, information collated by the hospice was not reviewed by the trust. For example, referral and patient outcome information.

Seven-day services

Key services were not available seven days a week to support timely patient care.

The service was still not available seven days per week. Services were only available Monday to Friday, with out of hours advice offered by the local hospice. This was still not in line with the NHS Seven Day Clinical Standards (2017) which states that specialist palliative care should be available at any time of day or night. The trust was aware of this shortfall and this was on the haematology and oncology risk register due to staffing shortages. However, plans were in place to extend the specialist palliative care team availability to seven days, commencing in September 2021.

End of life care

Mortuary staff did not routinely work at evenings or weekends but were on call and told us they would come in if a body needed to be released during these periods. They told us they could release a body in a timely manner if all relevant paperwork was complete.

Chaplains were on call at evenings and weekends and aimed to respond promptly to urgent requests, however the lead chaplain was currently not available due to sickness absence. Staff explained that there was a recognition with the chaplaincy to expand the staffing and a recent interview had taken place which resulted in the appointment of two additional chaplains equating to 1.5WTE.

Health promotion

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

We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

Staff assessed each patient's health when admitted using the initial assessment documentation.

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, consent was not always clearly documented.

The service had improved practice when carrying out and completing Mental Capacity Act assessments for all patients who were deemed to not have capacity. Mental capacity assessments were fully completed, and decisions made, were consistently documented and had a clear rationale.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Assessments documents included specific reference to capacity and assessment outcomes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. However, staff did not always clearly record consent in patient records. Consent was not included in the 'Caring for adults in the last few hours and days of life' document.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training compliance figures showed 100% for those staff who were identified as requiring this course.

Staff could describe and knew how to access relevant policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to articulate deprivation of liberty applications and referral processes to request mental health advice and support.

End of life care

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness. Privacy and dignity were generally respected but there were issues when caring for patients after they had died.

Staff explained end of life care was provided where possible using the SWAN or side rooms. During inspection we observed patients being cared for in this way. Patients families told us that if their loved ones needed to be moved for any reason, staff took the time to explain this to them.

During inspection we observed several staff and patient interactions, which demonstrated staff's kindness and respect for privacy and dignity. Staff cared for patients with compassion.

Patients said staff treated them well and with kindness. A patient on ward 33 told us that this was the 'best hospital they had stayed in' and the staff were 'amazing'.

Last offices were not always carried out for the deceased prior to arrival at the mortuary. Last offices is the term given to the care of the body after death, Mortuary staff explained the omission of this care by ward staff, resulted in patients arriving in an undignified manner. Mortuary staff explained that the impact of this for visiting families was significant and potentially highly upsetting.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress.

The end of life team had recently developed complimentary support boxes, which were offered to families at the discretion of ward staff. Boxes contained woollen hearts, drinks vouchers, parking discounts and support and advice. All wards we visited were able to provide these boxes.

Staff explained there were currently no arrangements to enable patients' families to view the deceased in the mortuary. Viewing arrangements had been stopped during the peak of

the pandemic by senior leaders of the organisation, and there were no plans in place to review this rule. Mortuary staff explained that viewing had been arranged for one patient as a special request, but it was not clear why this single request had been supported whilst others were declined.

The children's viewing within the mortuary room was not fit for purpose. The room, which was utilised and used as a fridge, was not appropriate for families wishing to spend any time with their loved ones, due to the temperature and noise from the refrigeration system. Mortuary staff explained however, that the refrigeration system was not switched on at the time of viewings.

End of life care

The bereavement survey dated May 2021 showed that 100% of families stated that they were given the opportunity to see their relative, on the ward, after they died. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement team staff told us they were able to support bereaved families as they had received training regarding difficult conversations through Sage and Thyme. However, in the same survey we saw 71% of families felt that religious / cultural and spiritual beliefs had not been taken into consideration, when liaising with the bereavement office staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their conditions and make decisions about their care and treatment. However, this was not always timely.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were encouraged to complete a bereavement survey and feedback was shared at the end of life steering group and fed back to all staff.

However, staff did not always support patients to make advanced decisions about their care. Referrals to the palliative and end of life teams were not timely, and early identification was not systematic across the trust. As a result, although those who were identified as needing the support of the team were unable to make decisions and on many occasions, these were late and reactive, rather than proactive.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisation to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Staff did not have a comprehensive system to identify the total number of patients who could benefit from their services, so did not know the level of unmet need in either the trust itself, or the wider community.

The service did not monitor inappropriate referrals. As a result, the palliative and end of life care teams identified the needs of some, but not all, of those requiring palliative or end of life care within the community they served.

The service worked closely with the local hospice, relying on their telephone advice line out of hours when no specialist hospital team was available. However, they were not working with the wider palliative care community providers to plan care.

The service had basic systems to help care for patients in need of additional support or specialist intervention, but these did not identify all patients. The palliative and end of life care teams relied on wards to make referrals to them,

supported by an electronic system which flagged up patients in the very last days or hours of life. This system did not identify all patients who were receiving palliative or end of life care, and teams felt they would not be able to meet demand if it did. However, once patients were seen by the team, they were able to refer to other specialist support such as speech and language, physiotherapy and dietitian services.

Meeting people's individual needs

The service was generally inclusive and usually took patient's individual needs and preferences into account. However, there were issues which meant this was not the case for everyone. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards where people received care towards the end of their lives could access dementia and mental health champions.

There were EOL champions based on some wards, but they did not link up with each other to share learning or provide peer support. Staff told us they had plans to make the EOL champion training more structured and build in more support.

Staff equality and diversity training levels were at 84%, which was below the trust target of 90%.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents which were well completed.

The service did not provide information leaflets available in languages spoken by the patients and local community but could access translation facilities when needed. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

There were no restrictions placed on friends or families wishing to visit those receiving end of life care. Staff explained that where possible, patients would be moved to a SWAN room, or other single room area to ensure that patients' privacy and dignity was maintained, and that friends or relatives had the opportunity to stay with them overnight. This had been difficult to achieve during the last year due to COVID, as infection control had taken precedent, but additionally one SWAN room onsite was out of use.

Chaplains visited patients when requested by ward staff. They explained that often this was very late in a patient's illness. There was no electronic system to alert chaplains that a visit was needed. All of the chaplaincy team were Christian; however, they could access external faith leaders in a variety of faiths. A 'dial a chaplain' service, advertised in public places, was innovative but poorly thought through, requiring a member of the public to use the trust switchboard which was not easily available to visitors.

There was no separate multifaith room in the trust for patient and family use. The chapel had fixed Christian symbols and therefore could not be easily adapted to become a non-denominational space. Staff following other faiths had found other space to use elsewhere in the trust, but chaplaincy staff had not been engaged during this process.

End of life care

Access and flow

Patients could not always access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death, where known, were in line with good practice.

Managers monitored waiting times but could not ensure patients could access services when needed. The team did not provide a seven-day service so patients could not always access support when they needed it. Evidence in a patient's notes showed, they were referred to the team on a Friday, who was not seen by them until the Monday. Notes showed that their pain was not well controlled in the meantime. The service's monitoring showed that in 2021, the percentage of patients waiting more than a day to access support from the team had risen from 15% in January to 18% in March 2021. We did not see an action plan to improve this

The end of life team saw an average of 39% of all patients who died at the Royal Shrewsbury Hospital (RSH) in 2021, which was better than the Princess Royal Hospital. As there was no catchall system in place to ensure they could accurately assess who would most benefit from their input, the team had no way of knowing that the remaining, majority of patients who passed away at the hospital did not need or would not benefit from their care. Additionally, the teams did not have a way of recording patients seen by both teams (potentially duplicating work). Ward staff told us that sometimes a patient could have several visits from both teams on the same day, as care was not coordinated.

Managers and staff worked to make sure that they started discharge planning as early as possible. Of those patients known to the palliative care team, just over 88% achieved their preferred place of death. However, not all palliative patients within the trust were identified. Therefore the trust could not accurately reflect their achievement of preferred place of death as they only recorded the outcomes for the patients who had been referred to the relevant teams.

Staff planned patients' discharge. Patients nearing the end of their life could be referred to a fast track discharge pathway, with a target of getting a patient to their preferred place within 48 hours. However, fast track discharges were not achieved. We reviewed the last 91 discharges across the trust and saw the average discharge time for the fast-track discharge of patients in receipt of end of life care was just over three days.

Trust policy stated that the complex care discharge team, who worked seven days a week, should co-ordinate end of life discharges. However, in practice this was done by the palliative care team, who did not work over the weekend, and as a result end of life rapid discharges over the weekend were rare. This impacted on patient's preferred place of death.

Staff supported patients when they were referred or transferred between services. Partner services receiving patients felt they were well informed, although delays in discharge, usually caused by transport, had led to people not moving between services seamlessly. We did not see an action plan to improve this.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Staff working on wards described how they would endeavour to resolve complaints informally and as soon as possible. However, the trust did not provide evidence of the end of life care team's involvement in the investigation of any of the

last three complaints relating to patient deaths, even though it was clear from one response letter that the team had seen the patient. Specialist staff were not able to recall when asked the last complaint they had had input into. There was therefore a lack of assurance that complaints were being appropriately categorised and discussed with the end of life care team.

Staff could give examples of how they used patient feedback to improve daily practice.

The end of life team had been asked by a carer if the new kindness hearts provided to patients and their loved ones could continue. The team have agreed that kindness hearts will become an integrated part of their practice.

Is the service well-led?

Inadequate 

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

Leadership

Leaders had the skills and abilities to run the service. They understood the issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff spoke positively about leaders and the support they had offered throughout the COVID-19 pandemic. However, mortuary, chaplaincy and bereavement service staff did not feature on the schematic diagram provided to CQC to explain the service's leadership structure, and bereavement services sat under a different management structure. Therefore, the team was not cohesive and there was disconnect within the existing communication systems.

Leaders were aware of and could articulate the current issues faced by the service in terms of capacity, and a historical separation between teams which they had plans to address.

However, they did not recognise the overreliance on the experience of individual practitioners or the effect their failure to monitor outcomes was having on patients receiving or wanted to access the service. This meant there was a lack of effective oversight of the quality of the service and the impact this had on the patient's quality of care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to underpin this aligned to national priorities. The vision and strategy were focused on sustainability of services, but it was not clear how they would monitor progress.

The end of life care strategy document, which included the specialist palliative care team, covered the period 2019-2022. There had been no revisions to timescales or adjustment of aims to incorporate the challenges posed by the COVID-19 pandemic.

End of life care

The strategy set out six aims, underpinned by sub-statements. However, the aims were not clear objectives, and as such were not clearly measurable, time-limited and focussed. For example “all clinical staff to be able to recognise all forms of distress” and “good communication between all staff” were wide ranging, difficult to measure and it would be almost impossible to show the service’s individual impact towards meeting the objective.

The strategy featured ‘indicators of success’ but these were not tied to aims or objectives, so it was not clear how the service would know that it had improved, and how it would know if it was on track with its aims.

Monitoring of the end of life care strategy through the specialist palliative care steering group was unclear, as although there was a standing agenda item titled ‘strategy’ this was not used to record progress against stated aims or flag any areas that were behind schedule.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, but did not always see end of life care as everyone’s responsibility.

End of life care was not a tangible priority on wards. Ward staff were not fully engaged in making dying everyone’s responsibility. This was reflected in the fact that in more than one area, staff did not recognise patients under their care as end of life or palliative, even when prompted.

Staff within the EOL team told us they felt valued and respected.

The trust were unable to identify EOL team responses to the staff survey due results for small teams not being published as that would identify individual team responses in a small team, and no other evidence of a mechanism for capturing or identifying the views of the team was provided to CQC.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

There were areas of the service which continued to be of concern and had been previously identified during our inspection in 2020.

The trust had developed a memorandum of understanding with their local hospice to provide mutual support with a view to improve both services. However, this was in draft at the time of inspection, and did not contain any detail of how the effectiveness of the agreement would be monitored.

The trust did not monitor its current use of out of hours support provided by external partners and there were no channels of communication, by which to share themes and learning from the out of hours support.

The most recently planned audit programme fails to measure the performance or quality of the end of life care service. An audit plan had been produced for 2021-22. The trust normally contributed to national audits such as the National Audit of Care at the End of Life and planned to do so in future (having briefly suspended over the COVID-19 period). Audits conducted over the previous 12 months and the audit plan for 2021-22 focussed on the implementation of, or changes in practice by, ward staff, rather than any quality monitoring of the end of life team, their record keeping or effectiveness. Therefore, the trust did not measure quality improvements to the service.

End of life care

Action plans were not implemented even when poor performance or practice had been identified through audit. Where issues had been identified in audits, for example, in the 'compliance with the care after death policy in clinical practice' audit of April 2021, where 63% of deceased patients were transported to the mortuary in a less dignified manner, there was no associated action plan, and results were not discussed (or not documented) at the next end of life care steering group in May 2021. Staff delivering the training to ward staff around the importance of good care immediately after death explained that they had been asked to deliver training once which was poorly attended and had not been asked to revisit this.

The governance around the end of life care steering group was inconsistent. A review of the terms of reference and steering group took place in early 2020. The end of life steering group met monthly and was generally well attended. However, the agenda did not state who was chairing, whether the meeting was quorate, and had no regular space for mortuary staff to input or provide updates.

Management of risk, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The team did not hold their own separate risk register. Risks for the end of life team were recorded within the oncology and haematology risk register. Two open risks related specifically to the end of life and specialist palliative care team. These included a shortage of specialist palliative care consultant input and a risk that the size of the team was not sufficient to meet the expected patient demand.

Senior leaders knew what the major key risks were for the team and explained what was being done to address this. However, other risks, such as those relating to the cleanliness of mortuary areas and capacity in the chaplaincy team were not stored centrally on the risk register and were therefore not being actively addressed.

Not all relevant staff had received an individualised COVID-19 risk assessment despite working across all wards during the pandemic. In addition, the associated risk of staff becoming ill due to COVID-19, were not included on the risk register.

Information Management

The service collected limited data. The information systems were integrated and secure.

The service was not using data to monitor performance or quality. The service did not have any systems to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level and did not work to any key performance indicators. However, leaders explained there were plans to implement both elements. This was a risk to patients as the lack of quality metrics and key performance indicators meant the service did not know, other than anecdotally, whether what it was doing was adding value or improving outcomes for patients.

Engagement

Leaders and staff engaged with patients and families. They collaborated with partner organisations to help improve services for patients.

The trust had continued to gather feedback from bereaved friends and families throughout the difficult COVID-19 pandemic period. Feedback was generally positive, however, in June 2021 30% of people thought that their relative was not free of pain in their last days, and 40% felt that their hygiene had not been maintained. These results were not discussed at the end of life steering group and it was not clear what had been done to act upon this feedback.

End of life care

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

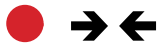
Learning, continuous improvement and innovation

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

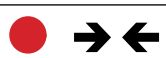
Members of the team had been awarded the Dundas medal for their work 'taste for pleasure' work using a patient's favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

During the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

Urgent and emergency services

Inadequate 

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

Mandatory training in key skills was not completed by all staff, including the highest level of life support training.

The trust provided mandatory training in key skills but they did not ensure all staff completed it. There were 15 mandatory training skills and the trust set a compliance rate of 90% for each one. Compliance to the highest level of life support training was not achieved.

Nursing staff did not keep their mandatory skills training up to date. For example, data obtained during our inspection showed infection prevention and control was 72%, fire training was 73%, the two-yearly manual handling training was 59% and information governance was 73%.

Nurses did not all have the level of higher life support training recommended by the Royal College of Emergency Medicine (RCEM). Current life support data for nurses was intermediate life support training (ILS) 85%, paediatric intermediate life support (PILS) 60%, European advanced paediatric life support (EPALS) 54% and advanced life support adults (ALS) 54%. Access to training had been impacted nationally and locally by the impact of Covid 19 with many courses stood down. The senior team had clear trajectories and staff were allocated to courses.

Medical staff received and mostly kept up-to-date with their mandatory training. Medical staff training mostly met the target of 90%. However, the compliance rates for information governance were 76%, hand hygiene was 58%, manual handling was 70% and PREVENT training was 82%.

Most medical staff kept their mandatory life support skills training up to date, however, advanced life support training compliance amongst junior doctors was slightly lower than the trust's target of 90%, with a compliance rate of 88%.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training covered a variety of training topics. Staff also undertook additional emergency department skills training, which included but was not limited to cannulation, taking blood cultures and paediatric nurse competencies.

The department had a clinical educator who was improving access to training. Senior nurses said their staff were required to complete many extra hours of training which was not accommodated for in the staffing establishment, however a business case was submitted to increase nurses and improve training opportunities.

Not all clinical staff had completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Nurse compliance mental health awareness training was 68%, and mental health crisis support was 54%; Mental Health Act training was 60% and dementia training was 64%. Amongst medical staff, only 74% had completed dementia training. Training in autism was not part of the trust's training programme.

Nurses told us they could access much of the training online from home, and that a phone app allowed quick access to some courses. One nurse said they did not get allocated time on the rota to attend most of the training and often training sessions were cancelled due to staff shortages. One nurse told us they completed their training from home and did not request their time back or payment, although they believed it was possible to request this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training data was on display in the ED corridor and in the staff room. Staff and managers were aware of training compliance.

Safeguarding

Not all staff followed processes to protect patients from abuse and not all staff had training on how to recognise and report abuse. The service worked well with other agencies.

Staff were not always up to date with the safeguarding training that would enable them to consistently recognise and report abuse. Nursing and medical staff did not consistently complete their safeguarding training which was specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training. All staff received level one children and adult safeguarding training when they joined the trust. Trust data showed compliance with children safeguarding level three training was 88%, and adult safeguarding level three was 70%. However, information received following our inspection showed nursing compliance to level three children safeguarding as 50% and we were therefore not assured of actual compliance in this area.

Medical staff had not received safeguarding adults level three training. This had been identified as an omission and there was a plan to start a bi-monthly training role out in September 2021. However, 84 % of medical staff had completed children's level three safeguarding.

Staff did not always follow safe procedures for children visiting the department. Some children left the ED without being seen and were not followed up by doctors the next day. Some children were not followed up for four days. ED consultants were required to check all children leaving for evidence of harm, and report monthly data to demonstrate they had followed up every unseen child, the next day. From 23 May to 19 June 2021, 33 children left without being seen. The trust provided details of 23 of these cases and showed that only four of these children were followed up the next day. Additionally, two children had no action recorded at all and two children had no date of the action recorded. The trust investigated incidents where children had not been followed up and shared details where a child, with suspected non accidental injuries, had left without being seen and was not referred to social services in a timely way or contacted by medical staff. The child was later removed from their parents. However, the actions to prevent similar occurrences included 'reminding staff' of the correct process. This was not robust enough for us to gain assurance similar events would not occur again.

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

Staff mostly knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Most children identified as being at risk while in the ED were referred to the trust safeguarding team and to the local authority appropriately. From July 2020 to July 2021, the department had made 211 children referrals and 50 adult referrals to local authority safeguarding teams.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service did not control infection risk well. Equipment and control measures were not always used to protect patients, themselves and others from infection. Cleaning records were not always completed to show the premises had been cleaned in line with their schedules.

Staff did not always follow infection control principles, including the use of personal protective equipment (PPE). Nurses did not wear appropriate PPE for high risk patients suspected of having COVID-19. When COVID-19 swabs were taken, and direct patient care was provided, this was carried out without the use of eye protection. Staff told us they only wore eye protection for aerosol generating procedures (AGP). This was not in line with trust guidance which stated eye protection should be worn for routine patient care when patients are suspected of having or have COVID-19, subject to a risk assessment. We were not provided with evidence showing staff were carry out risk assessments. Following our inspection, the trust updated its guidance to ensure all staff wore eye protection for direct patient contact. PPE compliance had also been highlighted to staff during a trust audit in June 2021, where it was noted staff in two areas of the ED did not wear gloves or aprons when within two meters of patients.

Patients were not routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. This was not in line with the Royal College of Emergency Medicine (RCEM) guidance February 2021, Emergency Department Infection Prevention Control during the Coronavirus Pandemic. We observed six patients booking in at reception and five patients being triaged. None of these patients were asked about signs or symptoms of COVID-19. All patients were directed to the same waiting area. Reception staff said they asked screening questions if the patient reported a known symptom, for example coughing. The triage nurse told us they did not screen for COVID-19 unless the patient showed signs and symptoms or self-reported signs and symptoms. Following our inspection the trust implemented COVID-19 screening for all patients on arrival to the department.

Patients with possible infections were not always identified and isolated in a timely way and there was a lack of awareness of basic isolation principles. One patient was admitted with a possible diagnosis of infective diarrhoea. This was not communicated to the nurse looking after the patient, and the patient was initially nursed in a two bedded bay in the clinical decision unit (CDU) before being moved to a side room. One patient with respiratory symptoms was nursed in the low risk COVID-19 area despite not having been screened for COVID-19. We saw a COVID-19 positive patient was admitted to the red AGP room while the doors were left open, increasing the risk to other patients in the area of virus exposure.

Staff did not always have access to appropriate hand hygiene facilities. Outside of the red bay in the red area, where staff doffed their soiled PPE, there was no alcohol gel or handwash basin. In CDU there was no hand hygiene sink in the dirty utility and the sink in the pitstop/CDU nurses' area was none compliant with hand hygiene sink standards.

We did not see staff routinely washing their hands with soap and water after patient care, including after removing gloves following contact with bodily fluids. Staff used alcohol gel following patient contact.

Cleaning records were not always up-to-date and did not demonstrated all areas were cleaned regularly. For example, the general cleaning checklist on the ambulance corridor had not been signed for five days in July and 14 nights in July 2021 (up to 20 July 2021). The red area resus room had no record of cleaning on 16 or 19 July 2021, day or night. A trust audit carried out in July 2021 identified that although some cleaning checklists had been ticked to say the cleaning was done, some areas were still found to be dirty.

Staff did not clean all equipment after patient contact or label equipment to show when it was last cleaned. Beds and trolleys were cleaned between patients but equipment was not always cleaned. We saw five patients being triaged who had their observations taken using the same devices. None of the devices were cleaned before or after each use.

All areas were clean and had suitable furnishings which were clean and well-maintained. However, there were several areas throughout the department where the flooring had been stuck down with tape and others with sticky residue. It was not possible to effectively clean these surfaces.

Following the inspection, the trust were made aware of the concerns regarding infection prevention and control in the department. The trust immediately implemented an action plan. The action plan covered the areas of concern and was to be monitored regularly by senior staff and the director of infection prevention and control.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well.

The design of the environment did not follow national guidance. The emergency department (ED) premises were outdated and did not meet guidance from Health Building Note 15-01: Accident and emergency departments planning and design or the 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care. Building work to improve the department was ongoing during our inspection, and some improvements had been made since our last inspection. Building plans showed more space and extra cubicles would be available upon completion of the work.

Environmental standards for children in the waiting room, required the area to be monitored to protect children from harm, and to provide the ability to contain someone wishing to leave against clinical advice, was not met.

The ED environment was not secure. All areas of the ED were accessible to staff, patients and visitors, including the resuscitation bay. Vulnerable patients were not always protected from people who may pose a threat to their health and wellbeing.

Equipment was accessible and could be damaged or stolen. The dirty utility door in the minor's area was wedged open giving patients access to used linen, clinical waste, sharps bins, plus some diluted and undiluted cleaning chemicals. This had previously been highlighted by an internal audit of the department in June 2021.

Patients presenting with acute mental health concerns had access to one room which met national guidance relating to the provision of a safe environment. This had improved since our last inspection. However, patients using this room had access to toilets and bathrooms which were unsafe environments with ligature risks and access to equipment. Ligature risks in the toilets had been assessed in March 2021.

Patients using the mental health room had a security guard with them most of the time. However, this was not always the case, and it would have been possible for patients to move freely about the ED. Reducing ligature risks had been incorporated into the ongoing refurbishment.

There were four small resuscitation bays in the department but there was insufficient space to comfortably accommodate all the staff and equipment required during an emergency. One of the resuscitation bays was dedicated

to children, however it was not exclusively for children and was regularly used for adults. During our inspection a child waited in the resuscitation bay for six hours before transfer to the children's ward at Princess Royal Hospital. This was an unsuitable environment for a child. Building work was ongoing during our inspection. Once completed, a designated children and young people emergency zone and resuscitation bay would be available.

The majors area cubicles and corridor were crowded with equipment, staff and patients. The side room doors were too narrow to fit a proper bed, and equipment, required during cleaning, was constantly moved to allow ambulances trollies entry. Security staff observing patients at risk of harm also provided another corridor obstacle along with electrocardiogram (ECG) machines, bladder scanners and lifting equipment, which was required regularly to aid patient care.

Patients were sometimes cared for in the ED corridors, including overnight during our inspection, leaving even less space for movement in the event of an emergency.

The pit stop area used for assessing patients and carrying out initial tests was often used as an extra capacity area for patients awaiting hospital admission. The CDU area was used to cover surges in demand and therefore lost its ability to function as a CDU facility. This included accepting patients who would otherwise be nursed in the major's area.

There was no fit to sit area due to building work in the department.

Staff did not always carry out daily safety checks of specialist equipment. Checks were not always completed on all emergency equipment trolleys. For example; within the red area resuscitation bay, one emergency equipment trolley had no checks recorded on 1, 9, or 13 July 2021 and bay two had no checks recorded on 3, 4, 9, 13 July 2021. The main resuscitation trolley in the red corridor had no recorded check on 18 July 2021 and there was no recorded check of the airway trolley for several months. In the major's area of ED, the paediatric bay resuscitation equipment (which included children's airway equipment) was not checked for five days in June 2021 and the resuscitation 'general' equipment trolley in majors was not checked for 3 days in July 2021. The resuscitation fluid warmer temperature checks were not done for five days in July 2021.

The emergency airway trolley in the red area of ED was unlocked and assessable to all patients' staff and visitors. This trolley contained items which would be required in an emergency to insert an airway into the patient, for example intubation tubes and four vials of medicine.

Staff did not dispose of clinical waste safely. National guidance on waste disposal was not always followed. Used PPE, including gloves and aprons was disposed of in domestic waste bins. One triage room had three bins, including an unlidded 'wastepaper basket'. This contained both confidential patient information and empty drinks bottles. An unlidded sharps bin in the major's dirty utility area contained a used IV line alongside empty medicine bottles, used urine sample pots, unopened cans of beer and used batteries.

The service did not have suitable facilities to meet the needs of patients' families. Relatives of seriously ill patients could not always access the relative's room. The room was frequently used for patients due to capacity in the department.

Most patients had access to call bells and staff responded as quickly as possible when called. Some patients in the majors area during our inspection were left waiting longer than expected before their call bell was responded to. Two patients who were unable to use their call bell were heard calling out for assistance.

The service mostly had enough suitable equipment to help them to safely care for patients. However, the department layout and doorway restrictions meant it could only accommodate six hospital beds for patients at risk of skin damage. Two additional air mattress trolly toppers were available.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff completed risk assessments on patients admitted to the department and tried to remove or minimise risks.

Patients were booked in at the emergency department (ED) through reception or with the nurse navigator. They were then seen by a triage nurse for an initial assessment in time order, unless they presented with a red flag condition, such as suspected stroke. The triage nurse used a recognised triage tool to categorise each patients' risk score. Higher risk patients were seen by medical staff sooner.

National guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in ED was not always met and many patients waited more than 15 minutes from arrival time to their initial assessment and triage. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. During our inspection children were triaged within 15 minutes of arrival. However, in July 2021, only 62% of children were triaged within 15 minutes of arrival, and the longest paediatric wait for triage was 94 minutes. In June 2021, the average time to paediatric assessment was 21 minutes

Adult patients were not triaged within 15 minutes of arrival for 29 patients out of the 34 patients we reviewed. The longest wait for triage was 5 hours and seven minutes. In June 2021, 50% adult of patients were triaged within 15 minutes of arrival.

There were delays for patients arriving by ambulance despite some patients having serious conditions. For example, during our inspection an elderly patient with a fractured hip and dehydration had been on the ambulance for over three hours and many other patients over 75 years old had waited between two and three hours before accessing the ED.

In April 2021, there were 346 occasions where an ambulance was delayed more than an hour before handing over the patient to ED staff. The trust and the ambulance services were monitoring these delays which impacted on patient care and delayed ambulance arrival times for other patients who may require one in an emergency. The proportion of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover was considerably higher than the midlands and England averages. As of 27 June 2021, 19.0% of patients waited over 60 minutes. This compared to the midlands average of 5.9% and England average of 3.8%.

Medical staff reviewed patients waiting on ambulances. Some ambulance patient records had evidence of a brief review by medical staff documented in their notes. The medical review contained an instruction that ambulance staff continue to monitor the patient and admit them as soon as possible. A dedicated nurse navigator reviewed patients who arrived by ambulance. The navigator also assessed ambulance patients, however they did not always record the times of their assessments.

The divisional leadership team and ED staff were clear patients held on ambulances were the responsibility of the hospital, however, because they were in the care of health care professionals, it was deemed safe for patients to remain on ambulances.

Urgent and emergency services

There were long delays in transferring patients to specialist care outside of the resuscitation bay. We saw an adult patient who required dialysis and ITU care. The teams of doctors outside of ED did not agree an appropriate pathway for this patient, which left the patient at an increased risk of harm and blocked a resuscitation bed. We also saw a child, who required transfer to the local children's ward, had waited many hours in a resuscitation bay bed space, despite not requiring this level of care.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients attending the ED who had their observations taken, had an early warning score recorded, which was used to identify those at risk of deterioration. The department used a National Early Warning Score (NEWS) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. The NEWS score was calculated using a handheld device for recording patients' vital signs.

The NEWS we looked at during the inspection were escalated and monitored in line with frequency rules. The trust audited their compliance to frequency rules and the results varied. The four-week average compliance in July 2021 assessed by the departments own staff was 97%, and 56% when assessed by departmental peers.

National guidance relating to the assessment, recording and monitoring of children's vital signs was not always followed. The Royal College of Paediatrics and Child Health recommends that, children presenting with a medical illness or significant trauma should have a set of vital signs recorded. Not all patients attending the ED had their observations taken, including some children. Triage staff told us they made a clinical decision as whether a set of observations was required.

The trust audited their sepsis care. The four-week average compliance to screening in July 2021 was 98% and compliance in respect of appropriate antibiotics within 60 munities was 91%. During our inspection we looked at two patients with sepsis, both of which had been given antibiotic treatment outside of the recommended one-hour timeframe, and although most records showed patients had been screened, we found two patients who had not.

Risk assessments for each patient were mostly done on admission using a recognised tool and reviewed regularly. Staff knew about and dealt with any specific risk issues. Risk assessments for falls and pressure damage were included in the patient's admission documentation pack along with bed rail assessments.

The pressure damage risk assessment included a tick checklist, and a visual inspection of the patient's skin. The visual records were not completed in the records we looked at. Instead staff had written the patient self-reported their skin was intact. Patients identified as being a high risk for pressure damage, and who were in the department for a long time were transferred onto a hospital bed, although some patients had already been in the department or on the back of an ambulance for several hours on a trolly before their assessments were carried out.

Falls risk assessments had been completed, although a patient identified as having a high risk of falling, did not have the required falls wrist band.

VTE risk assessments were completed electronically and doctors told us these were normally completed prior to prescribing preventative medicines to patients. VTE assessments had been completed on the records we checked, and patients had been prescribed preventative medicines.

The service had 24-hour access to mental health liaison and specialist mental health support for patients who presented with acute mental concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for patients

thought to be at risk of self-harm or suicide. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours that placed them or others at risk. Some patients required physical interventions in the form of physical restraint to keep them and others safe.

National guidance was not always followed to ensure the risks associated with restraining patients were being mitigated. For example, from 5 April to 14 June 2021, restraint was used 52 times, 22 of these where chemical restraints. Post restraint observations were not recorded for seven of these 22 patients and although all patients had a body map completed prior to restraint, six patients did not have a body map completed post restraint. Any related injuries may be unreported.

Staff mostly shared key information to keep patients safe when handing over their care to others. Verbal handovers were provided when transferring patients to ambulance staff. Doctors shared information with GP's when patients were discharged from the department.

ED consultants monitored children who left the department before being treated and were required to contact the family within 24hours of their attendance to identify any harm as a result of children leaving before treatment. In the week commencing 14 June 2021, 3.5% of all children left the ED before being seen. From 23 May to 19 June 2021, 33 children left the department without being seen. The trust provided details of 23 of these cases and showed that only four of these children were followed up the next day. Additionally, two children had no action recorded at all and two children had no date of the action recorded.

Process to follow up adult patients who left the department before completion of treatment were not robust. Some adults who presented to the department with potentially serious symptoms, including chest pain and pregnancy related concerns, left before being fully assessed. Patients who left before any treatment was given had a basic discharge summary sent to their GP. However, medical staff we spoke with could not confirm this always happened, and there were no audits to check this. Patients who had started treatment and left before its completion would have a discharge summary sent to their GP automatically.

Shift changes and handovers included all necessary key information to keep patients safe. The trust's Urgent and Emergency Care Survey 2018 scored significantly worse than other trusts for giving information about how to get test results after leaving the ED.

Staffing

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. Staffing gaps were filled with temporary bank and agency staff and gave them a full induction.

The service did not have enough substantive nursing staff and support staff to always keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers. Due to recent activity levels in the department, the numbers had been increased by one nurse and one HCA for both day and night shifts. Planned emergency department (ED) daytime staffing was now 15 qualified nurses and at night 12 qualified nurses.

Current staffing requirements had not been calculated using a recognised staffing tool, for example, the Royal College of Emergency Medicine (RCEM) Baseline Emergency Staffing Tool. Senior nurses told us that the current staffing

establishment was not calculated using any recognised tool or method, and believed if a recognised tool was used, a bigger establishment of nurses would be determined. A business case had been submitted for more nurses and HCA's to be added to the emergency department (ED) establishment requirements, however nurses were unsure when or if this might be approved. Following our inspection, managers told us nurse staffing in the ED had been calculated using an adapted nurse staffing tool and the RCEM Baseline Emergency Staffing Tool. Nurse staffing was on the departmental risk register.

The major's area was allocated three nurses and one HCA and accommodated 12 patients. One nurse was often moved to cover another area of the ED. During our inspection, two nurses and one HCA were caring for 12 majors' patients. The nurse in charge had been asked to open the ED corridor to accommodate ambulance arrivals but was unable to do so due to nurse shortages. Additionally, the department tried to incorporate an ambulance handover nurse on its roster with responsibility for a cohort of up to four ambulance patients. Staff shortages meant this role was not always filled. Similarly, the pit stop was not always fully functional due to nurse staff shortages.

The standard operating procedure for the clinical decision unit (CDU) required it be staffed by one nurse and two HCA's. During our inspection, one nurse only was allocated to this area.

The ED was short of three nurses during the two days of our inspection, and additionally on day two it was short an HCA and an emergency nurse practitioner. This impacted on patient care. For example, patients had not been kept up to date with the plans for their treatment. All patients we spoke with told us staff appeared very busy although they were trying to help as much as possible. One member of staff reported they would go without their break because there was no one who could safely relieve them.

During the four weeks from 13 June to 10 July 2021, the ED staff rota showed shifts were down a qualified nurse on 13 out of the 28 days. Most of the shortages were for one nurse, although on four occasions the shortage was for two or three qualified nurses. However, these gaps were only what the e-rostering system identified as gaps, and this was based on the programmed e-rostering establishment figures. Senior nurses told us a larger establishment was required to improve patient care and safety.

The trust did not have enough registered children's nurses (RCN) to meet the Royal College of Paediatric and Children's Health (RCPCH) guidance and were unable to ensure two RCN's were available on each shift. In order to reduce the risk of this, the ED aimed to have one RCN and one adult nurse who had completed a set of children's competencies on duty. The trust was unable to meet this requirement every day. During our inspection there were no RCN and only one nurse in the department who had children's competencies on the day shift on 20 July 2021 and there were no children's nurses scheduled for the night shift. At the time of our inspection, most band six and band seven nurses had theses competencies, however, only 8% of band 5 staff nurses had completed these. There was a training plan to address this shortfall. Senior nurses told us there was an ongoing campaign to recruit more children's nurses and that some had already been appointed and were due to start very soon.

The service had reducing rates of bank and agency nurses. All shifts from January to April 2021 had more substantive staff than agency staff and the department's reliance on agency staff had declined steadily from 41% in September 2020 to 23% in April 2021.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Staff shortages were discussed at bed meetings throughout the day and had oversight of any shortages. Senior managers moved clinical staff to improve safety.

The department manager could adjust staffing levels daily according to the needs of patients. We saw managers requested extra staff when the department was full and they wanted to open the corridor to handover patients waiting on ambulances.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff we spoke with during our inspection all worked regularly in the ED and knew how the department operated.

Managers made sure all bank and agency staff had a full induction and understood the service. The service used an agency induction booklet and checklist for new starters.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. There was a high reliance on agency and locum staff. There were four whole time equivalent (WTE) consultants in the emergency department (ED). This did not allow the service to meet recommendations from the Royal College of Emergency Medicine (RCEM), that consultant staffing in the ED to be present in the ED for a minimum of 16 hours a day. At RSH consultants worked Monday to Friday from 8am to 10pm and from 9am to 3pm at weekends. On call cover was provided at all other times.

Clinical leaders told us it required ten WTE consultants to run safely and effectively.

The trust had been unable to recruit a paediatric emergency medicine consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings. Paediatric advice was available from the Princes Royal Hospital in Telford.

Medical staffing was on the department risk register.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The locums used were regular doctors who had worked in the service for some time.

The service always had a consultant on call during evenings and weekends. Weekend consultant cover was by locums only as there were insufficient substantive consultants to cover this period.

There were gaps in the medical rota that the service were unable to fill. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads said they reviewed staffing to ensure it was 'adequate', and as safe as possible. However, we found there was insufficient middle grade doctors allocated to cover the weekend hours and that the department relied heavily on junior doctors. At night, there were only two registrars available. During the inspection, a registrar grade doctor was allocated to cover the resuscitation bay, where the sickest patients were nursed, while the more senior consultant covered the major's area and carried out some administrative tasks. The layout of the department meant the most senior person was not always visible or immediately locatable.

The service had high vacancy rates for medical staff.

There were ongoing plans to recruit new staff and managers were creative in employing experienced senior registrars to fill consultant roles within the department.

The service reviewed its skill mix of medical staff on each shift regularly. There were less consultant staff working in the ED than the England average. In January 2021, 11 % of medical staff were consultants, the England average was 29%. 34% of medical staff were middle career grade doctors, 47% were registrars and 8% were junior doctors. *(Source: NHS Digital Workforce Statistics.)*

Managers told us they required 44 middle grade doctors to cover Royal Shrewsbury Hospital and Princess Royal Hospital, Telford. There were currently 28, dropping to 20 in August as middle grade doctors moved to training places and promotions outside of the trust. The department had trained and recruited some advanced nurse practitioners and emergency nurse practitioners to support junior doctor roles.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Not all records were stored securely.

Staff could access patient notes easily but notes were not always comprehensive. Nursing and medical staff had access to patients' paper and electronic records. Records contained information about the patients care and their risk assessments. Some ongoing care records were ticked and did not contain details of interventions. For example, the hourly check proforma included a pain section which was mostly ticked and did not recording a pain score, or interventions, and the food section was ticked, but no details of what the patient had been offered was recorded.

When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff. Some staff reported delays in scanning.

Records were not always stored securely. Notes trolley were unlocked throughout our inspection and in the clinical decision unit area, patient notes were left unattended on top of the nurses' station.

Medicines

Staff mostly followed systems and processes when prescribing, administering, and recording medicines. Most medicine was locked away.

Staff followed systems and processes to safely prescribe, administer and record medicines. Medicines administration records were maintained to show the medicines that had been prescribed had been administered. The allergy status of patients was recorded.

Some patients experienced a delay in being given their medicine once it had been prescribed. We saw some delays in the administration of some antibiotics which ranged from 45mins to 1hour and 45mins, and there were some delays in the commencement of IV fluids of up to two hours. Delays also occurred in prescribing medicines as a result of patients waiting in ambulances to access the department.

Analgesia was not routinely offered during triage. Triage nurses told us they did not always offer analgesia at triage because it required a doctor to prescribe it, which would increase delays. Triage nurses told us patient group directives (PGDs) were no longer available in the department, and so they were unable to offer simple analgesia themselves. Following our inspection, matrons told us PGD's had been available in the department and had recently been updated. Pharmacists confirmed PGD's were available and were unaware staff were not using them.

Some paediatric medicines were not always available, especially at weekends and out of hours. Stock levels of paediatric medicines were currently being reviewed with advice from pharmacy. Medicines were delivered twice a week and alternative treatment advice was provided if any medicine was not available.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Doctors reviewed patient's medicines on admission which was documented in patients notes.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescribing documents were stored safely in dedicated secure storage areas. FP10 prescriptions were stored securely with a checking system to track their use. New improved security systems had been implemented which ensured only authorised staff had access to medicines. Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated.

Staff mostly followed current national practice to check patients had the correct medicines. Dedicated sepsis trollies were available for the immediate treatment of sepsis. Medicine reconciliation was undertaken by doctors in ED. Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine.

Guidelines on the safe dosage of some paediatric medicines were not available at the point of use. For example, intranasal diamorphine, for children in severe pain. This medicine required titration based on the age and weight of a child and is available in different strengths. It is important when administering this medicine that the correct amount is used. Medical staff we spoke with were unsure about the guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles and in team meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines used to manage agitation or aggression (rapid tranquilisation) were prescribed following appropriate safety checks and in line with guidance.

Incidents

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

Urgent and emergency services

Staff knew what incidents to report and how to report them and staff raised concerns and reported incidents and near misses in line with trust policy. We looked at some incident reports submitted by the trust. Staff gave examples of incidents they had reported. Delays to patient care as a result of delayed ambulance handovers were not routinely reported as incidents due to the amount of administrative work this would involve, although if there was a harm identified by the delay, staff said this would trigger an incident report.

Staff shared feedback from investigations and incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Incidents were shared across ED departments and at daily managers meetings and cascaded to staff as required. Local incidents were discussed in daily huddles and at team meetings. There were messages of the week, and any themes from incidents were used as messages. Not all staff reporting incidents received feedback from managers in relation to incidents they had reported. However, leaders were aware of this and were instigating new processes to improve this.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence that changes had been made as a result of feedback. Senior nurses described how patients were invited to contribute to investigations, where appropriate.

Managers debriefed and supported staff after any serious incident. Staff discussed a recent event in the department and we saw evidence that staff had been given the opportunity to receive support.

The service had no never events or serious incidents in the previous 12 months. Managers shared learning with their staff about never events that happened elsewhere. Staff were not aware of any recent never events in the trust but could articulate what one was.

Safety Thermometer

The service collected patient safety data. However, this information was not always up to date or clearly displayed for patients and staff to view.

The service continually monitored safety performance. Quality performance reports were displayed on the triage corridor which was not easily accessible for patients. The reports displayed were for April 2021 and were printed directly off the trust quality dashboard system on A4 paper. The information was difficult to read and interpret for lay people. However, the information demonstrated the service were carrying out quality audits. Most areas were compliant, except for nutrition which was red and scored 71%. Medicine management scored 80% and tissue viability scored 82% and both were flagged as amber. There was no falls information displayed.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Urgent and emergency services

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance and staff had difficulty in accessing these. There were some checks to ensure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. For example, printed guidance for the pathway management of diabetic ketoacidosis in adults (DKA) was dated June 2010, despite a national guidance update in 2021. An electronic version sent to us following our inspection was also dated 2010, although the trust's DKA policy had been updated in line with the recent guidance.

Medical staff told us electronic guidelines were difficult to find and were located under different directorates and there was no one central catalogue of guidance. Mangers told us this had been recognised and that they were hoping to release a directory of all trust guidance soon. We were told if staff were unable to find the correct guidance, or guidance which they believed was sufficiently in date, then staff followed national guidelines instead.

Audit information was collected regularly. For example; compliance with sepsis screening and escalation of deteriorating patients. Actions following any audited non-compliance included individual coaching and teaching and any departmental learning points were discussed at daily huddles and team meetings to raise awareness.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Records we checked during the inspection showed staff had followed the correct Code of Practice to protect patients subject to the Mental Health Act 1983 (MHA). Patients presenting with self-harm and suicidal ideation were given one to one support by security staff and had received all the required mental health assessments, risk assessments and authority to detain. Trust data for June 2021 showed 100% of patients appropriately received a mental health triage assessment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

Nutrition and hydration

Staff did not have access to specialist support staff or assess all patients using a nationally recognised screening tool. Staff mostly gave patients enough food and drink to meet their needs and improve their health once they were inside the department. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not use a nationally recognised screening tool to monitor patients at risk of malnutrition. We were told nutritional screening was done on admission to the ward. However, many patients were in the department a long time and could arrive with a poor nutritional status.

Specialist support from staff such as dietitians and speech and language therapists was not available for patients who needed it. Patients had a basic swallowing assessment from nursing and medical staff, and those identified as at risk were placed on nil by mouth until admitted. Intravenous fluids were provided instead.

Staff mostly made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs once inside the department. However, there were long delays in accessing care which left some patients without food and drink for a long time, and there were some delays in starting intravenous fluids for dehydrated patients. Some patients on the back of ambulances were given water and offered snacks, although some trust harm reviews undertaken on patients waiting over four hours found there was no evidence that food or drink had been offered.

We did not see any records where a patient's nutritional preference had been recorded, for example, requires a soft diet only. A department nutritional audit for April 2021 showed compliance with nutrition was 71%.

Patients in the emergency department (ED) overnight told us they would have preferred hot food, rather than sandwiches.

Staff completed basic details in patients' fluid and nutrition charts where needed. ED checklists confirmed patients had been offered diet and fluids, although they did not always record what had been provided to the patient. Fluid balances were commenced for patients receiving IV fluids, but they did not always record any oral intake, or any output.

Pain relief

There were delays to patients in receiving pain relief and additional pain relief was not always offered. Patients did not routinely have a pain score assessment recorded on admission, although pain was monitored through the ED checklists. Staff supported those unable to communicate using suitable assessment tools.

Pain relief was not always given in line with individual needs and best practice and not all patients had a pain score recorded using a recognised tool on admission. Pain scores were not recorded at triage for seven out of the eight records we checked. Pain relief was offered to two of the eight patients. Local and national guidance on pain relief was not always followed. A child with a fractured elbow and a pain score of eight out of ten was given paracetamol only. Staff confirmed their policy would have enabled further pain relief to be offered.

Patients identified as in pain did not always have appropriate pain relief prescribed soon after it was identified they needed it. A patient reporting a score of nine out of ten at triage was not offered analgesia. A patient with a pain score of seven, recorded twice during their 19-hour admission, had not been prescribed any analgesia until the inspection team raised it.

Staff prescribed, administered and recorded pain relief accurately. We did not see any prescribing or recording errors on prescriptions.

Patient outcomes

Staff did not always monitor the effectiveness of all care and treatment. Some audit findings were used to make improvements for patient outcomes. Data supplied for some national audits was incomplete.

The service participated in relevant national clinical audits. This included the following Royal College of Emergency Medicine (RCEM) audits;

- RCEM Audit: Vital signs in adults 2018/2019
- RCEM Audit: Feverish child 2018/2019
- RCEM Audit: VTE in lower limb immobilisation 2018/2019

- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Audit results and actions plans were requested from the trust. The audits showed the service performed worse than the national average for all three of the 2019 - 2020 audits they participated in, and worse for one of the three 2018-2019 audits. Some of the audits contained incomplete data and therefore it was not possible to compare the results for all audits with the national performance. We were not provided with action plans although medical staff said they continually monitored the quality of their patient outcomes and followed up action plans to improve standards.

Outcomes for patients were not always positive, consistent or met expectations, such as national standards. For example, the Care of Children in the Emergency Department audit had a measure that included infants who were at high risk of potential safeguarding presentations were reviewed by a senior clinician whilst in the ED. This ED submitted one patient record only. This record failed to meet the standard. The standard to 'assess psychosocial risks using a national or locally developed risk assessment tool' was not met for any of the five cases submitted to the audit.

For the Assessment for Cognitive Impairment in Older People audit, the ED performed worse than the national average for all six measures for which its data was available.

The Mental Health (self-harm) audit showed the ED performed worse than the national average for eight of the nine metrics where data was available.

Managers and staff used the results to improve patients' outcomes, and to improve care and treatment. Action plans to improve performance were in place and were updated and discussed regularly within the medical teams. Junior doctors participated in audit data improvements and this formed part of their clinical education.

Managers and staff carried out a comprehensive programme of local audits to check improvement over time. Regular local quality audits were undertaken in the ED and the results were fed back into the trust's internal quality assurance systems. Externally reported audits were completed although some RCEM audits showed limited case inclusions which made compliance to standards difficult to ascertain.

Managers shared and made sure staff understood information from the audits. Audit results were discussed locally within the department, divisionally at quality meetings, and trust wide at board level.

The service had a lower than expected risk of re-attendance than the England average. The reattendance rate at this trust in May 2021 was 6% and 8% in the midlands.

Competent staff

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

Senior nurses were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses working in the emergency department (ED) were junior, new to the service or were international nurses who had recently joined the services training programme. This group of staff did not have all

the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, only 8% of band five staff nurses had children's nurse competencies and there was a plan to address this by October 2021. Following our inspection, managers told us that 96% of ED staff who were responsible for children in the department, had completed all of their children's competencies.

Managers gave new staff a full induction tailored to their role before they started work. The induction period was flexible to accommodate individual learning requirements and new nurses told us they were happy with the training and support they were receiving in the ED.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 80% of ED nurses and 84% of medical staff had an in-date formal appraisal recorded. Although this did not meet the trust target of 90%, staff had access to ongoing one to one support and development conversations. Delays in appraisals were largely due to the extra pressures on staff during the COVID-19 pandemic.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high quality training which covered their learning needs. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

The clinical educators supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. The department had recently appointed a full-time clinical educator to ensure staff had the right support and access to relevant training. Each ED nurse was required to complete 49 hours of training annually and a business case had been submitted to ensure ED nurses had access to all this.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or by a dedicated staff app. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily huddles around the white board included all disciplines of staff. Leaders described how they worked closely with the medical division to improve medical reviews and access onto a medical ward if required. The frailty team were active in supporting staff and patients in the emergency department (ED), although there were no inpatient frailty beds at the hospital. The frailty team included occupational therapists, physiotherapists, advanced care practitioners, a geriatrician and a social worker.

Staff mostly worked well across health care disciplines and with other agencies when required to care for patients. Doctors from the medical team worked in the ED regularly to assess and care for their patients. Speciality doctors were

mostly responsive when asked to review patients in the ED although there were delays for some patients. For example, a patient required admitting and a disagreement over which department would accept the patient meant there was a delay in treatment and the patient remained in ED longer than necessary. Another patient waiting ten hours for a surgical bed was refused the bed when it became available because a CT scan had not been performed.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service worked closely with ED staff and provided advice and support when required.

Seven-day services

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

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

The frailty team was available Monday to Friday and the last referral time was 4pm. Saturday occupational therapy and physiotherapy cover for the emergency department (ED) was included in the hospital site therapy weekend rota but was not dedicated to ED patients, although dedicated support was available on Sundays.

There was good access to imaging 24 hours a day, seven days per week and staff were not concerned about any delays in reporting or accessing results.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the emergency department (ED). Leaflets were available and given to patients for a range of conditions and we saw staff signposting patients to other helpful services during triage.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patient's physical, psychological and social needs formed part of the ED admissions booklet. Patients were referred to their GP for continuing support if required.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients records had evidence of appropriate assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some emergency department (ED) nurses had clearly recorded they had sought consent from a patient before carrying out an intervention.

Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff described how they supported children to make decisions about their care and treatment.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards, they did not all keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data showed 60% of nurses had completed this training at the time of our inspection. Senior nurses told us training was booked for most nurses. Medical staff compliance was 86%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Is the service caring?

Requires Improvement 

Our rating of caring improved. We rated it as requires improvement.

Compassionate care

Although individual staff members treated patients with compassion and kindness, the service was not designed in a manner that always respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

Although we found improvements since our last inspection, issues with the emergency department (ED) environment and staff numbers meant patients did not always receive meaningful compassionate care.

We inspected the ED at a time when it was under enormous pressure due to the volume of patients trying to access services and having lower than planned staffing. Patients waited longer for staff to attend to their needs and many were left on the back of ambulances or in the waiting room for a very long time. Less patients were cared for in the ED corridor than during our previous inspections, but some patients were nursed there overnight, and others waited for many hours on a trolley in the back of an ambulance. Patients sat on the floor outside of ED and some patients waiting to access the service were not offered analgesia, even after triage.

Staff tried to remain discreet and responsive when caring for patients. Staff worked hard to protect the privacy and dignity of patients, despite working in a heavily congested and busy department. Interactions between nurses, doctors and their patients demonstrated kindness and compassion. However, we observed that staff did not always have enough time to spend with patients beyond carrying out essential tasks. Some patients in the major's area appeared confused and were unsupported for long periods of time.

Urgent and emergency services

Patients said staff treated them well and with kindness. All patient we spoke with were happy with the care they had received and felt grateful to the staff looking after them. However, most patients also said that the nurses appeared very busy and used phrases such as ‘’always running about’’, and ‘’trying their best to look after everyone’’.

Staff mostly followed policy to keep patient care and treatment confidential. Although staff tried to keep treatment and conversations confidential, the environment was such that most conversations could be heard by other patients, staff and visitors. For example, in the major’s area, we overheard a private conversation regarding a patient’s personal hygiene care needs, and we heard a medical assessment which included how much alcohol the patient drank daily. The reception area booking in windows were close together alongside the waiting room meaning it was difficult for confidential information not to be overheard. Notes trolleys were not locked, and in the CDU area patient notes were left on top of the nurse’s station. Patients and visitors were free to walk around the ED as all areas were freely accessible. Some bay curtains and doors were open meaning patients could be freely observed. Private areas were not always available, for example the family room, as it had been used for an extra patient bed space.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Security guards in uniform were used to look after patients who presented with mental health concerns and who were at risk of self-harm. Guards accompanied these patients throughout the ED, including outside and in the waiting rooms. We observed a female patient in a side room was being observed by two male security guards outside of her windowed room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they had access to resources on cultural needs and were able to offer these to patients as required. We were told most patients moved out of the ED before requiring culturally specific care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The dedicated relative’s room was unavailable during our inspection however staff said an alternative private space was available for families if required. Most of the emergency department (ED) was open, and conversations could be overheard, although staff pulled curtains round bed spaces, and closed doors where these were available.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There was an end of life support box available which contained resources for families.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the life changing conditions some patients presented with and discussed these sensitively with patients.

Understanding and involvement of patients and those close to them

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

Urgent and emergency services

Staff did not always make sure patients and those close to them understood their care and treatment. Patients were told of their care journey through the emergency department (ED) during the triage process, although patients waiting a long time were not kept up to date with delays and waiting times. We spoke with patients waiting outside after triage, who had been there for several hours, and who said no one had spoken to them since their initial assessment, and they wondered if they had been missed. We saw some patients return to reception to request an update and reception staff were unable to provide this. Some patients waiting to be admitted to a hospital bed told us they were not aware of what their plan of care was. Waiting times were not displayed.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff spoke with patients, families and carers using language they could understand, and communication tools were available if necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about the Friends and Family Test (FFT) and the trust's complaints service was available in the department, although engagement in the FFT low. Managers were aware of this and were working on alternative ways to gather patient feedback.

Staff supported patients to make advanced decisions about their care. Patient's wishes for their end of life care and resuscitation decisions and a preferred place of death were recorded using the ReSPECT form as recommended in guidance.

Is the service responsive?

Inadequate 

Our rating of responsive stayed the same. We rated it as inadequate.

Service delivery to meet the needs of local people

The service was not designed in a way that always met the needs of local people and the communities it served due to the department's infrastructure and pressures within the local healthcare system. Managers and staff worked with others in the wider system and local organisations to plan care.

The emergency department (ED) at Royal Shrewsbury Hospital was open 24 hours a day, seven days per week. A public consultation (Future Fit) took place in 2018 confirming the agreed way forward for the future configuration of clinical services, including emergency services. A Strategic Outline Case is being finalised for submission to regulatory and national bodies seeking approval and funding for the resultant Hospital Transformation Plan.

Managers tried to plan and organise services to meet the needs of the local population, although they were hampered by an unsuitable environment, premises and a lack of inpatient hospital beds. The facilities and premises were not appropriate for all the services being delivered. Children spent a long time in adult resuscitation bays and the children's treatment room was normally used for adults. There were insufficient toileting and washing facilities and the lack of a medical admissions unit meant some patients stayed overnight in the department on trolleys when they would otherwise be admitted to a bedded area with bathrooms. The waiting room could not accommodate the number of patients wanting to use the service and the number of seats had been reduced further due to social distancing measures. Many patients sat on the ground outside the emergency department (ED) for a long time while waiting to be

seen. A patient who said they were unable to walk was sat in a wheelchair for over five hours outside. At the time of our inspection the trust was in the process of redeveloping the department and plans showed some of the environmental issues would be addressed by the improvements. However, this did not address the bed capacity in the hospital which was identified as still being a challenge despite the improvements.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff said any mixed sex breaches in the clinical decision unit would be reported, although those we asked, were not aware of any recent mixed sex breaches. Mixed sex rules were not applicable to other areas in the ED.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Patients' records showed they had been referred appropriately and had been seen by supporting organisations. Dementia support staff worked in the trust and visited the ED to provide support and guidance to staff.

The service had systems to help care for patients in need of additional support or specialist intervention. Physiotherapy follow up clinics were run within the ED to provide advice and support to patients who presented with musculoskeletal injuries. ED staff had access to specialist nurses with a range of skills including tissue viability, sepsis, infection control and safeguarding.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead.

Managers and staff worked with other providers to organise care. Patients were assessed on arrival to ensure they were treated by the most appropriate service and were redirected to the onsite GP service, urgent care centre or to primary care if required.

Leaders worked closely with the commissioners and community providers to find system responses to the capacity issues both in the ED and the wider trust and were active members in the regional urgent and emergency care group. They met monthly with the ambulance service to improve services.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet most of their needs. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided. Staff did not always have enough time to support and respond to the individual needs of all patients.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Dementia nurses supported emergency department (ED) staff to complete 'This is me' passports. However, the ED environment was not designed to meet the needs of patients living with dementia. The CDU area had a 'twiddle box' which contained items of distraction for patients who might benefit from this.

There was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

Care plans were used for patients who attended the department frequently and these patients were easily identifiable on each admission.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing system was available at reception and staff sought to provide any additional support patients required as a result of their disability.

All printed information leaflets were in English, although staff had access to some online information in alternative languages which they could print for patients. Leaflets and signs in the department were in English which was in line with a large proportion of the local demographic. There was no information available in Welsh, despite the ED being close to the border.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpretation services were primarily provided over the phone, although staff said they could get them and signers into the ED if required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Staff said they had access to other food types and were able to meet patient's individual preferences.

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell below national standards.

Patients could not always access emergency services when needed and did not always receive treatment within agreed timeframes and national targets. Managers monitored waiting times.

During our inspection, the service was operating under severe pressure and patients had long waits for every stage of their emergency department (ED) attendance. This included for some patients, over four hours to disembark from ambulances, over four hours to access triage, and over four hours to see a doctor. Capacity in the department was on the ED risk register.

Department leads said they were hampered by the lack of an acute medical assessment unit where ED patients could be directly admitted to. This area had been converted to a red pathway during Covid-19. Nurses said the lack of a discharge lounge impacted on their ability to get patients out of the department who were waiting for transport, or medicines to take home.

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard and performed worse than the England average over the 12 month period from May 2020 to April 2021. In April 2021, the trust reported an average time to treatment of 82 minutes. This was longer than the England average of 57 minutes.

The proportion of patients who attended by ambulance and waited over 60 minutes from arrival to handover from 7 March to 27 June 2021 was higher than average across the Midlands region and across England. As of 27 June 2021, 19% of ambulance patients waited over 60 minutes; the Midlands average was 6% and the England average was 4%.

Urgent and emergency services

On 20 July 2021 at 9am, compliance to the RCEM guidance to see, treat, admit or discharge within the four-hour target was 53%. On 19 July 2021, at 3pm, there were 19, 12-hour breaches with ten more patients about to reach their 12 hours wait.

Managers and staff mostly worked to make sure patients did not stay longer than they needed to. ED staff tried to facilitate care as quickly as possible for every patient. A newly created flow coordinator role helped to get patients moving through the department and identify any delays as early as possible. At the time of our inspection, it was too soon to access the impact of the new role on patient flow through the department. However, an ED nurse in charge told us the flow co-ordinator undertook some of the jobs they previously had to do and it therefore gave the nurse in charge more time to focus on running of the department.

ED doctors reported that speciality staff mostly reviewed their patients while in ED as quickly as possible and that there was a memorandum of understanding to ensure this process was escalated if necessary. We saw some delays for patients awaiting a specialist review during our inspection.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. However, ED staff said trust leaders did not always escalate the department pressures sufficiently high or in line with guidance, to ensure the maximum external support was always available. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status.

During our inspection the department had declared a level three OPEL, with level four evoking the maximum system supports possible. The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff felt they were working at level four but did not always feel empowered to take action.

The number of patients leaving the service before being seen for treatments was low. The trust reported similar numbers to other trusts, both locally and nationally. There had been a steady increase in patients leaving before being seen since January 2021.

Managers and staff worked to make sure they started discharge planning as early as possible. The frailty team attended the ED to assist with discharges. There was a trust wide initiative to free up hospital beds earlier in the day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it.

The trust were working with commissioners and community providers to access rapid response nursing teams who could help patients going home and prevent some admissions. However, at the time of our inspection, there was no date known when this service might start.

The trust worked to reduce the number of patients admitted to hospital following attendance at ED. In June 2021, the trust admitted 24% of all type one attendances which was below the England average.

Staff planned patient discharges carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment. However, there was a national shortage of mental health inpatient beds, and this was reflected in the number of patients with mental health needs staying in the department longer than was necessary. We observed one patient, who was waiting for an inpatient mental health bed, who had been in the department for more than 35 hours.

Staff supported patients when they were referred or transferred between services. Navigators and triage staff provided information to patients who were referred to other services, such as the out of hours GP service.

Managers monitored patient transfers and followed national standards. Children were transferred to other hospitals using recognised safety standards. Children's nurses were trained specifically for this.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. Information was available in the emergency department (ED) waiting areas on how to make a complaint. Complainants received a response from the ED within 15 days of making a complaint. The ED received more complaints per 1000 patient attendances than most other ED's in the country. Out of 123 ED's the trust was ranked number 102.

From April to June 2021, there were 17 complaints and six compliments. In June 2021 the department received 12 complaints, most of which were about clinical care and treatment.

Staff understood the policy on complaints and knew how to handle them. Nurses told us they provided patients with information about the Patient Liaison Advisory service (PALS) if they were unable to resolve a complaint at the time. However, nurses said they always attempted to resolve a patient's concerns locally and at the time of the incident.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers. Complaints were discussed at clinical governance meetings.

Recent complaints were mostly about delays to care. Formal complaints were discussed during divisional governance meetings and where appropriate lessons were learned, they were shared throughout the trust.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us they kept the patient and family up to date with complaint progression as soon as they were able. Managers were allocated administration time in order to respond to complaints.

Staff could give examples of how they used patient feedback to improve daily practice. This included feedback from the patient volunteer group and local Healthwatch who had made suggestions to improve the environment in ED following feedback they had received from patients.

Urgent and emergency services

Is the service well-led?

Requires Improvement 

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

Leadership

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

The emergency department was managed under the medicine and emergency care division and was run by the divisional medical director and divisional director of operations. The leadership structure in the emergency department side of the division consisted of a clinical director, centre manager, and divisional director of nursing and divisional deputy director of nursing. The nursing team were led by a matron who was supported by a team of band seven nurses who took charge of the daily operational running of the service.

Local leaders were clear about their own roles and accountabilities. Some staff said the trust wide management team were not always fully sighted on the real time issues faced by the department or fully aligned with the departments view on finding solutions. For example, during our inspection the department was under extreme pressure, however trust managers had not declared a level four OPEL incident. Internal actions had been set in place which were aligned to level four incidents, but the failure to declare a level four externally meant some systems of support which may have been available, had not have been fully explored. ED leaders said this occurred regularly. From April to July 2021, OPEL level four had been declared five times, and OPEL level three had been instigated 53 times. The trust did not always declare a level four if they still had an intensive care bed available.

Local leaders expressed some frustration because when extra actions were required these largely fell to ED staff. For example, nurses said some tasks undertaken in ED could be done by nurses working in other directorates, and although nurses were occasionally redeployed to ED to cover a shift, shortages were largely left to the department to absorb via more creative staff rostering and the use of extra bank and agency staff. Staff said there was little visible support provided by other specialities in the trust.

Divisional leaders told us they visited the department and spoke to staff during walkabouts. They reported using a ‘’ask five questions’’ methodology, whereby they asked different staff the same five questions to gain an insight into what was happening in the department.

Nursing staff told us the nursing and medical leadership team were very visible in the department and that other members of the senior leadership team had recently become more visible. Some staff said senior leaders came to the department only when it was under extreme pressure.

The ED matron supported the daily running of the service along with an increased number of band seven nurses. Each band seven had a group of junior staff which they managed along with a specific area of responsibility in the ED, for example, lead for safeguarding.

There was a band seven nurse in charge every day who had oversight of each clinical area and was required to maintain an overview of patients in the department. When the department operated at maximum capacity, and had up to 60

patients present, it was not possible for one person to have full oversight of every patient. This had been recognised by the leadership team who introduced a more senior leadership structure in the ED. This included recruiting more band six nurses whose role included leading staff covering each clinical area, for example, the major's area. Staff we spoke with were enthusiastic about the impact this would have on the smooth running of the department and on patient safety.

Vision and Strategy

The service had an emerging vision for what it wanted to achieve and an emerging strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There were seven strands to the strategy. These were; excellence in patient care, leadership, team recognition, wellbeing, professional development, shared decision making and the workforce of the future.

Clinical staff did not specifically discuss the strategy however it was clear work was underway in some of the identified areas. For example, the recently appointed clinical educators assisted with professional development and allowed each nurse to receive two weeks of training before the end of this financial year.

There was an operational plan which set out how the trust intended to respond to local and national challenges. The plan included trajectory improvements in meeting performance such as a reduction in ambulance handover delays and improving four hour waits.

Staff were aware that some of the improvements they planned were dependent upon external factors, including hospital bed capacity, accessibility of GP services and primary care, and the availability of skilled doctors and nurses. Nevertheless, ED leads were also aware of where more local changes were needed to make service improvements. For example, there was a lack of electronic prescribing of medicine which impacted on patient discharges, and the availability of therapy staff to support speedier patient assessments. One of the successful ED priorities, to reduce the number of patients cared for in the ED corridor, had improved the working environment for staff in ED. However, patients were still unable to access the service ay quicker and were held instead on the back of ambulances.

The trust were involved in addressing external issues collaboratively and were active members of the urgent and emergency care delivery group. They worked closely with other providers, 111 services, commissioners and Health Education England in order to realise their strategy.

Senior members of the ED met regularly along with other senior departmental representatives to discuss the trust's "Getting to Good" Plan

This involved identifying actions in each area which would impact on the safety, quality and effectiveness of the care they provided. This helped to ensure many of the concerns identified in the ED were discussed as trust wide issues, and not just problems isolated to the emergency department.

Culture

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

All staff we spoke with said they felt respected, supported and valued, and that communication in the department had greatly improved recently. In our previous inspection, some staff reported a bullying culture from senior leaders however we did not hear that during this inspection. CQC received a written allegation of bullying during our inspection although matrons told us they were not aware of any allegations of bullying in the department. Nurses told us they were aware of how to escalate concerns around bullying and they were aware of the trust's freedom to speak up guardians.

Governance

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

Clinical governance meetings were regular, well attended and covered a wide range of issues including for example, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

Lessons learned from incidents and complaints were discussed in the department newsletter and formed part of the junior doctors teaching. Some junior doctors told us they were not aware of incidents and complaints.

Management of risk, issues and performance

Leaders identified some relevant risks and issues and identified actions to reduce their impact. Staff did not always contribute to decision-making to help avoid compromising the quality of care. Some risks were not always escalated. Leaders and teams used systems to manage performance and had plans to cope with unexpected events.

The risk register contained identified risks and a latest review date, a record of when the risk was added to the register and an audit trail with the history and updates for each risk.

Not all risks were listed on the register or managed well. For example, in July 2021, the trust had 751 overdue incidents across both ED's. There was a risk that some preventable incidents may go undetected. The risks associated with extreme demand in the ED were not always agreed and staff expressed frustration at the trust's response to their concerns. For example, when ED leads believed they were working at level four OPEL and required maximum support from the system to reduce risks, there was discrepancies with managers about how this should be managed.

Decisions about when to accept patients in the ED corridors were not always made with clinicians in the department. The SOP for handling ambulance queues included a statement by senior clinical ED staff that they did not approve of any corridor care as it was never safe or appropriate and it did not allow for social distancing. The trust were unable to provide details about how many patients had been cared for in the corridor, or for how long.

Some senior staff in the department believed the changes to the environment did not go far enough in addressing the current issues and said that although some performance, staff and patient experiences would improve, the changes would not solve all of the problems associated with demand, capacity and flow at the hospital.

Performance was discussed at team meetings. However, actions from these were not always completed. For example, our inspection identified an airway trolley in the red resuscitation area had not been checked for several months. This had been discussed at the ED leads meeting on 1 June 2021 yet had remained unchecked on 20 July.

Executive leads were aware of the real time position of ED in terms of current waiting times, delays, staffing issues etc. Feedback was provided to them following the 'safe today' divisional calls. Overall, ED performance was reported monthly to the board. Monthly meetings were held with the ambulance service where both organisations worked on improving the quality of services.

Local improvement plans had been agreed with commissioners, including an agreement that achieving the four-hour target for 95% of patients was unattainable. An alternative trajectory meant the trust was aiming for 85% instead. However, in June 2021, the trust was off its trajectory, achieving 68% instead of the planned 71%.

Information Management

The information systems were not integrated and staff could not always access patient data when they needed it. The service collected some pertinent data and analysed it. Data or notifications were consistently submitted to external organisations as required.

The trust emergency department assurance report for June 2021 identified there were seven items in their CQC improvement plan that remained off track, which were attributed to IT problems in the emergency department (ED).

The ED used paper and electronic records to care for patients. Paper records were scanned so they were accessible if a patient returned to ED. Some doctors told us there were sometimes delays in scanning.

The ED recorded patient observations using a different scoring system from the rest of the hospital. ED staff used an early warning score (EWS) and hospital staff recorded a NEWS2 score. We were told this was because there were different electronic systems used in the hospital to record patient observations.

Prescriptions for medicine were paper based, which led to some delays in prescribing medicines and arranging for medicines for patients going home.

Sepsis screening and paediatric observations were not recorded electronically, unlike other patient observations. Paper records were used which made audits more difficult.

Guidelines were not all stored in the same place on the trust intranet and there was an issue with version control for printed copies of some documents, although there was a working group set up to rectify this. A prototype new ED intranet page was about to be tested which contained direct links to all trust guidelines. There was no timescale for implementation.

Some data provided by the trust was incomplete or contradictory, for example training data and data concerning the number of patients cared for in the corridor.

There was no system of displaying waiting times although there was a plan to introduce this.

Engagement

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

Leaders told us they engaged with patients through Healthwatch and through their patient volunteer networks. However, due to the COVID-19 pandemic, there had been limited opportunities to engage with patients.

Emergency department staff said they tried to encourage patients to give feedback and to complete friends and family surveys but the demands in the department regularly meant this type of activity was not possible.

There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade. Staff were also encouraged to identify changes that would improve patient care and safety and there was a closed social media group for staff to share ideas for improvements.

Learning, continuous improvement and innovation

Staff were committed to learning and improving services, although high demand in the department meant there was not enough time dedicated to improvement initiatives and outcomes. Some quality improvement methods were used, and staff were learning to implement these. While staff were focussed on performance, there was little time for innovation.

Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

The departments new nurse staffing structure, which included a dedicated, on site matron, more senior nurses and a clinical educator allowed for greater monitoring, oversight and training opportunities.

However, high demand for services, insufficient nursing and medical staff, poor patient flow and an inadequate physical environment had meant many of the quality improvements required were not achieved.

The trust was compliant in providing CQC with information. Some of the information supplied did not evidence sufficient improvement and some items on their improvement plan remained off track.

Some of the newly implemented quality improvements had not improved care for patients at the time of our inspection. For example, the new on site SDEC had not specifically improved patient assessment times or enabled targets to be met, and although the frailty assessment team helped assess elderly care patients quickly, it was not available seven days per week. There was no acute medical assessment area or designated frailty ward for these patients to be looked after in.

The environmental upgrade which was ongoing during our inspection was unlikely to improve flow out of the department and it would not significantly increase the department bed base or give patients more access to admission beds. Corridor care had been reduced, but this had impacted on ambulance delays and had not led to overall improved patient care.

In our previous comprehensive inspection in 2019, 26 regulatory breaches covering eight regulations were identified. During this inspection, 14 of these breaches remained, covering five regulations. We also found one new regulatory breach relating to pain management.

The Princess Royal Hospital

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Description of this hospital

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

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

The urgent and emergency care service at Princess Royal Hospital (PRH) provides services 24-hours per day, seven days per week service. The hospital is the main receiving centre for the acutely unwell child. The ED comprised of booking in and streaming area, a main waiting area, a children's waiting area for those aged under 13 years, one triage room, a three bedded resuscitation bay, eight majors' cubicles, a four bed 'pit stop', a respiratory isolation unit, (RIU), that could accommodate up to two patients in separate side rooms plus additional space for patients well enough not to require a trolley. The RIU operated limited hours, opening at 10.30am and closing at 10pm, four minors' cubicles providing care to patients who presented with minor injuries, a fit to sit area; a children's assessment and treatment cubicle, and a "Pit stop" or rapid assessment area for patients arriving by ambulance, or for those patients who self-presented to the ED who were prioritised by nursing staff.

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

The end of life care service comprised of two service lines, a specialist palliative care team and an end of life care team. The palliative care team at Shrewsbury and Telford Hospitals NHS Trust works across both hospitals. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

During our inspection we visited all areas within urgent and emergency care and maternity and wards 7, 9, 10, 11, 15, 16, 17, acute medical unit and endoscopy.

We spoke with 140 members of staff, including doctors, nursing staff of various grades, healthcare support workers, physiotherapists and managers. We spoke with 27 patients and we looked at 75 sets of patient records.

End of life care

Inadequate

Is the service safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training.

Mandatory training was largely delivered through the online learning portal but was not comprehensive to meet the needs of patients and staff. The trust mandatory training target was 90% but not all staff groups within end of life and palliative care met this target. Overall compliance for the team was 84%. Mandatory training requirements were different for the various members of the team. For example, the mortuary staff were not required to undertake infection prevention and control training. We requested further clarification from the trust but did not receive it. Data submitted by the trust showed palliative care doctors had not completed updated training for two out of the eight mandatory modules, which included fire safety and equality and diversity. Overall compliance was 75%.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Bereavement and chaplain staff did not receive Mental Capacity Act, Deprivation of Liberty and Mental Health Act training. This had the potential to affect patient care and lead to serious safety risks amongst the bereavement and chaplaincy services.

Safeguarding

Staff understood how to protect patients from abuse, however they did not always have training on how to recognise and report abuse or how to apply it.

Staff did not receive training appropriate to their role on how to recognise and report abuse.

The intercollegiate document 'Adult Safeguarding Roles and Competencies for Health Care Staff' 2019, states that all practitioners who have regular contact with patients, their families, carers or the public should complete level 2 Safeguarding Adults training. The trust target was 90% for Safeguarding Adults level 2, but not all staff groups met this target for their mandatory training. Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training requirements were different for the various members of the team. For example, at the time of our inspection, data showed palliative care doctors had not had update training for safeguarding children level 2, PREVENT level 1 and had not completed PREVENT level 3. The bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

End of life care

The intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Health care staff' 2019 states all non-clinical and clinical staff who have any contact (however small) with children, young people and / or parents/ careers or any adult who may pose a risk to children should complete level 2 safeguard children training.

Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training was again different across the staff groups and the bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

This had the potential to affect patient care and pose serious risks to patients due to staff not being able to recognise safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns but were unable to describe recent safeguarding referrals or any subsequent learning following them.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death. However, measures were not followed within the mortuary.

Ward areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained. However, staff did not always follow infection control principles. Staff were aware of current infection prevention and control guidelines, including the process for screening patients for COVID-19, MRSA and Clostridium Difficile, prior to and during an admission to wards. Staff observed social distancing where this was possible and wore appropriate PPE. There were handwashing facilities and PPE stations on wards we visited, which were well stocked and included information on PPE requirements.

The provider did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, which states that providers must provide and maintain a clean and appropriate environment in managed premises that facilitates the control of infections.

The mortuary was visibly unclean in several areas. Liquid was observed leaving the condensing pipe below the main refrigerated body store, creating a small pool of fluid which was green in colour. Inspectors noted odour in this area.

Bench surfaces in the post-mortem room were visibly unclean, and the area was cluttered. It was not evident when a thorough cleaning of this area had been carried out, as cleaning records did not include this detail.

The outdoor additional refrigerated bariatric body storage area, was found to have large amounts of visible dirt on the floor including general litter, chewing gum and debris from the nearby situated bins.

Cleaning records for the mortuary were not fit for purpose as they showed only signatures of the staff whom had carried out the cleaning. Staff were not able to describe effective cleaning processes and unable to articulate deep cleaning requirements for these high-risk areas. There were no policies or procedures to outline the cleaning requirements for the mortuary or the outdoor bariatric storage area. Staff explained that the outdoor storage area had recently been used but there was no evidence to show this area had been cleaned.

The lack of cleaning and supporting policies to ensure appropriate levels of cleaning had been undertaken, posed a significant risk of infection spreading to the immediate mortuary staff and throughout the hospital.

End of life care

Inspectors raised these concerns immediately with the trust, who arranged for a deep clean of the area and the subsequent development of draft cleaning processes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The mortuary had capacity for 30 patients in the main mortuary with additional storage in the adjacent refrigerated 'SWAN' room. The SWAN logo was used across the hospital to recognise end of life and the supporting end of life care team. Thermostatic checks were completed manually, due to the age of the refrigerators. Outside, another body storage area had been created which could accommodate three bariatric patients. Two temporary storage units were situated in what was the previous post-mortem room.

Staff explained there had never been an issue with capacity, but if this were to cause a problem, they would use their links with local funeral directors to manage flow through the unit.

Patients were transported to the mortuary by porters and all staff accessing the mortuary were required to log entry at all hours of the day and night. Records were up to date and completed appropriately.

Lighting in the outside body storage was broken with only partial illumination of one side of the area. This posed a potential risk of injury to staff entering the area, particularly during the evening and night.

Mortuary staff explained they were waiting for a chest freezer to be replaced which was used to store ice used during transportation. At the time of our inspection ice was obtained from other internal departments.

The service had suitable facilities to meet the needs of patients' families. However, side rooms were limited on the wards and demand for these rooms was high when dealing with infection control issues. The hospital had several SWAN rooms which were specifically developed and designed rooms to support patients receiving end of life care. The Princess Royal Hospital had nine SWAN rooms, one of which was unavailable at the time of our inspection, due to maintenance issues.

SWAN resource boxes, which were designed and provided by the End of Life team, were available on all wards we visited. These boxes had recently been introduced to assist ward staff with advice and support across all areas of palliative and end of life care.

The service had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. These were readily available and obtained from a trust wide medical device library and staff explained that arrangements to access syringe drivers had improved significantly since the last inspection.

Grab and go' boxes were introduced across all wards which contained relevant equipment to make up two syringe drivers.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

End of life care

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Risk assessments did not always consider patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risk assessments for each patient were completed upon admission but were not updated and reviewed consistently.

We reviewed the risk assessments records for four patients receiving end of life or palliative care and saw risk assessments such as tissue viability, falls, enteral feeding and pressure ulcer prevention were not reviewed consistently. One record showed a pressure ulcer assessment was carried out upon admission, which scored the patient as high risk, however a further assessment was not carried out until nine days later. Another patient record showed a falls assessment had been completed upon admission but was not signed by staff and was not re-assessed until a further seven days later. Upon review of another two records, these showed conflicting re-assessment dates when assisting patients with moving and handling needs. This had the potential to affect patient care and pose serious risks to patients due to the lack of staff intervention through regular assessment.

The service's application and use of ReSPECT forms still needed to improve. A trust wide audit of the use of ReSPECT forms was carried out in May 2021 and signed off in August 2021. It showed personal preferences were completed 76% of the time for those with capacity (22 out of the 7 patients with capacity). Out of the 66 patients with a ReSPECT form in place 33 were identified as not having capacity (52.4%), so unable to complete. It also showed evidence of a ReSPECT discussion was only present in 71% of patient notes, where they had capacity. The audit also highlighted 91% of patients had involvement in the making of their plan and only 42% was discussed with others when the patient themselves did not have capacity.

Specialist palliative care nurses and end of life nurses were accessed through separate referral processes. Ward staff were required to make a manual telephone referral as the trust did not operate an electronic system. Risks were not routinely requested or reviewed at this stage.

Some end of life patients were identified through an electronic system, as they had been assessed as requiring 'no observations'. This meant patients were often at the very end stage of their lives before they would be known to the palliative and end of life teams.

The criteria for referral to the End of Life team was the patient was deemed to be in the last 72hrs of life. There was no oversight across the whole of the hospital of all end of life or palliative patients, this posed a significant risk that individuals requiring intervention, did not receive it.

The service had still not established an effective system to ensure the identification of all patients, whom were at the end of life. Following inspection, the provider developed an action plan which included plans to address this.

Most staff shared key information to keep patients safe when handing over their care to others. However, during shift changes and handovers staff did not include all of the key information to keep patients safe.

The specialist palliative care and end of life teams carried out a 'huddle' each morning to identify which patients were to be seen within the hospital. Specialist palliative care staff explained they did not use a clinical triage system to

determine patient prioritisation or acuity. Basic information such as the name of the patient, reason for the referral and the name of the member of staff, whom was making the referral, was recorded. In the absence of a clinical triage process there was a potential risk to patients, who were at greatest need or at the highest risk, may not be prioritised effectively. Staff explained they would always try and see everyone, but this decision was not made on clinical need.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team. These teams worked across both the Princess Royal Hospital and the Royal Shrewsbury Hospital sites.

The end of life care team consisted of a whole time equivalent (WTE) band 7 end of life care facilitator and three band 6 end of life care specialist nurses. These nurses equated to the equivalent of 1.8 (WTE) staff and provided end of life cover across sites from 8.30am to 4.30pm. Cover was provided remotely on Friday afternoons, but there was also a palliative CNS available on Fridays and would review any End of Life patients.

An administrative assistant provided WTE 0.8 band 3 support. There were no vacancies within the end of life team at the time of inspection.

Nursing staffing levels still did not meet the minimum standard of the National Institute of Health and Care Excellence (NICE). These standards state access to specialist palliative care should be made available seven days per week. The specialist palliative care team consisted of six WTE band 7 clinical nurse specialists (CNS), two of whom has been recruited recently. The six nurses worked across sites and provided a service Monday to Friday 8.00am – 6.00pm and staffing was adjusted through the week to meet the needs of the patients across both sites. Out of hours cover including weekend cover was provided through an on-call service at a local hospice.

Staff explained that plans were in place to offer specialist palliative nurse cover, seven days per week from September 2021. This would include a palliative care team leader whom would manage the specialist palliative care nurses and the end of life care team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust employed 0.9 WTE palliative consultant who provided cover to both the Royal Shrewsbury Hospital and the Princess Royal Hospital sites, Monday to Friday. The cover was provided on site for four days of the week and one day remotely.

In addition, one palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.4 WTE cover to the trust. However, this position was a fixed term contract which was due to end in July 2021. There were no arrangements to provide ongoing cover after this time.

End of life care

Improvements in respect of consultant cover had been made but medical staffing levels still did not meet the minimum standard of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. Cover had been increased from 0.8 WTE to 1.3 WTE despite difficulties in recruiting. The trust had secured a budgetary increase to 3 WTE which they were currently recruiting too, however there was a shortage nationally.

Medical staffing recruitment was an ongoing challenge for the trust and several attempts to fill an additional substantive palliative care consultant post had been unsuccessful.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, and up-to-date. However, records were stored securely and easily available to all staff providing care.

The trust utilised paper-based records for assessment and care planning with vital observations such as blood pressure monitoring, oxygen saturation and pulse recordings logged electronically.

Patients receiving end of life care were commenced on the 'Caring for adults in the last few hours and days of life' care plan. However, as patients were not identified as requiring end of life care until 72hrs prior to death, this documentation was not utilised prior this point.

We reviewed trust guidance provided to staff to support them with the completion of the 'Care of the dying care plan' document and saw that guidance did not define appropriate timescales for the necessary completion of the document. This resulted in the care plans being incomplete which potentially impacted on the safe care and treatment patients received.

A new updated version of this care plan was to be piloted on wards 10 and 11, but they were not in use at the time of inspection.

The trust had not made improvements to ensure staff had access to the information they needed to provide person centred care. Patient records did not include a complete and accurate record that described patients' individual needs and preferences.

Patients receiving specialist palliative care support did not have bespoke documentation. Any intervention provided by the team was recorded within the patient's medical records, which posed a risk that this documentation would be missed.

We reviewed care of the dying care plans for two patients and saw that the document was not written to support staff to personalise care planning or record individual outcomes for patients receiving end of life care. For example, they did not detail specific nutritional requirements, comfort, spirituality, or communication. Staff explained that the new care plan would support staff to capture patients' wishes in this way and were awaiting training on the new document.

Some care plans had not been signed or dated, including enteral feeding and the admission pack had also not been fully completed. In another patient record, religious beliefs were not completed, although family explained that the patient had been visited by the chaplain. Skin checks were not completed in accordance with trust policy and anticipatory medicines (including syringe driver) were not ticked as required, despite the patient having a syringe driver in situ.

End of life care

We did see evidence of patients preferred place of care and do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients' notes and completed capacity and consent records in both records.

Records were located at the nurse's station and were stored securely.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, medicines were not always provided in a timely manner.

Staff followed systems and processes when safely prescribing, recording and storing medicines. A pharmacist visited wards Monday to Friday to review prescribing of medicines including palliative care and end of life care prescribing. The pharmacy team checked patient's medicines to ensure they were prescribed correctly, any discrepancies were identified and highlight to the relevant teams.

There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours.

Prescribing guidelines for anticipatory end of life care were available on the trust intranet. This included information on the medicines available and information on prescribing.

Anticipatory end of life medicines were available on all wards visited.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Patients weights were documented on all the medicine records reviewed.

Pharmacists checked that prescribed medicines were compatible when syringe drivers were used.

Pharmacy provided counselling and support to patients and carers to explain changes in medicines or when new medicines were started and allow them to raise concerns and ask questions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. However, we saw delays in patients receiving prescribed analgesia.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

End of life care

Incidents

The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. However, managers did not always shared lessons learned with the whole team and the wider service.

The trust were told they must ensure effective systems were in place to share learning from incidents to prevent further incidents from occurring. We requested the last ten incidents which were reported under end of life or palliative care and saw that there were themes associated with the lack of care provided to the deceased and medicines management, with the remaining incidents varying in theme.

Staff knew what incidents to report and how to report them. We reviewed an incident on ward 10 relating to care of the deceased. We saw the incident was investigated swiftly, and action taken to mitigate further incident. Staff were encouraged to reflect on the events of the incident and share learning across the ward.

We reviewed the minutes of the last end of life steering group meeting and saw that incidents were regularly discussed and reviewed. However, all staff we spoke with delivering end of life or palliative care were unable to identify any incidents that had recently occurred within the speciality, and we did not see any overarching trust action plans to address themes emerging. For example, care of the deceased, across the speciality. Therefore, we were not assured that managers within the speciality were aware of these incidents or had taken steps to share them.

Is the service effective?

Inadequate ➔➔

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

The trust developed the 'Caring for adults in the last few hours and days of life' care plan, which was developed for patients who were entering the last days of life and was designed to address the holistic needs of the dying person by providing supportive and compassionate person-centred care. The document introduced in 2014 by the trust, replaced the Liverpool Care Pathway document. Plans were in place to roll out an updated version of the care plan, but staff explained that the original version was the only document in use at the time of inspection, whilst staff awaited training.

Staff followed up-to-date policies to plan and deliver high quality care. However, this did not always follow best practice. For example, the General Medical Council (GMC) states that end of life patients are those identified as likely to die in the next 12 months. The trust's criteria for referral was 72hrs and documentation commenced at this point was not complete. We reviewed all documents relating to four patients receiving end of life care and found that documentation and care planning was inconsistent and, in some cases, incomplete. Two patients did not have the end of life care plan document in place, whilst the remaining two patients had a partially completed document. Staff explained that this was due to the patients no longer being assessed as 'end of life' or meeting the 72hr criteria for end of life care and the documentation was stopped. This was carried out in line with the trust's policy. Two of the four patients had completed recommended summary plans for emergency care and treatment patients (ReSPECT) in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment.

End of life care

The trust's last audit of the care of the dying care plan was October 2020, and results were mixed. In some areas of the document, such as evidence of conversation between the patient and the medical team responsible for their care was 33% and evidence of consultant involvement was 53%. However, evidence of conversation between patients loved and staff scored 100% and in June 2020, it was recorded that all twelve patients receiving end of life care were found to have the care plan in place. In the same audit 92% of patients had a recorded ReSPECT document in place.

Ward staff delivering end of life and specialist palliative care, told us they were able to access policies on the trust intranet. The end of life team had a dedicated website offering symptom guidance, referral pathways and general advice, which reflected national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that was available.

The trust did not have oversight of all patients requiring end of life or palliative care within the hospital. There was currently no electronic palliative care co-ordination system (EPaCCS). The trust utilised an electronic ward review system, but it did not incorporate any software for alerts or co-ordination of palliative care or EOL patients.

The service still did not have an effective system to identify where patients, at the end of life, were throughout the hospital.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw records within the generic nursing notes which recorded nutritional needs and evidence of nutritionist involvement. However, not all nutrition and hydration needs could be recorded using the care of the dying care plan, as the section in the care plan related only to artificial hydration and nutrition.

In addition, we saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care. Staff explained that the end of life team were supporting ward staff with additional mouthcare training.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the provider performed worse when compared nationally with other similar providers. For example, the risks and benefits of hydration options, were discussed with families and others in 10% of cases, compared to 35% nationally. For 72% of patients, no reason for not discussing this was recorded. This was worse than the national proportion of 49%.

The risks and benefits of nutrition options were not discussed with families and others for any cases. Nationally the figure was 28%.

Pain relief

End of life care

Staff did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.

We saw pain assessments were inconsistently documented for palliative and end of life care patients across the wards we visited. We saw varying pain assessment tools available to clinical staff, however we reviewed two patient records and saw only one completed pain assessment tool. Both the patients we reviewed had experienced pain or discomfort and had been prescribed analgesia.

The care of the dying care plan did not support individualised care planning regarding pain management and did incorporate a pain scoring tool. Tick box prompts were used if a patient was experiencing pain with a limited amount of space in the document to record evaluation.

Managers of the service told us that electronic pain scores were recorded as part of the electronic ward monitoring system. We reviewed two patients through this system and saw that pain scores were not completed.

Patients did not always receive pain relief, soon after requesting it. We visited two patients, who at the time were receiving end of life or palliative care and found both patients acutely in pain. One patient had been waiting for a review of analgesia, whilst the second patient had not received medication for pain despite asking staff several times.

Anticipatory end of life medicines were available to all wards we visited.

We reviewed the results of the most recent National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, anticipatory medicines for symptoms likely to occur in the last days of life were prescribed and administered in 34% of cases, compared to 68% nationally.

The service was not undertaking specific audits for pain or symptom management.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under any relevant clinical accreditation schemes

The service did not have an end of life care dashboard to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level. However, leaders explained that there were plans in place to implement both elements.

The end of life and specialist palliative care teams' input was monitored using forms, completed by the team, detailing how their patient was referred and what their input was. However, these documents did not monitor how comprehensive the team’s record keeping was, nor the effectiveness of their care in influencing outcomes for patients. The trust did not have a policy or process to define this, to ensure consistency of recording.

Managers and staff carried out a programme of audits to check improvement over time. We requested details of all audits relevant to end of life care, which were undertaken. We received audit details relating to the October 2020 National Care Audit of Care at The End of Life of (NACEL), Care after Death Audit, SWAN Room audits, Care of the

End of life care

Deceased mortuary audit, bereavement survey results, the End of Life Care Plan Audit February 2021, mouthcare and an audit of the Swan “Grab and go T34 syringe driver policy. The mouth care audit (which included all patients not just end of life patients) was dated September 2020, showed 41% of staff were not aware of the mouth care policy and 52% of staff stated they had used a mouth care chart.

Managers and staff did not use the results of these audits, to improve patients' outcomes and we did not see an action plan to address these findings.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

The trust included end of life as part of mandatory training for all staff. The trust provided training figures for end of life training with compliance being 80% as of July 2021.

The service did not have a clinical educator role, however, the team delivered and oversaw a programme training relevant to end of life and palliative care. Also, the end of life team offered bespoke training sessions to ward staff when requested. Ward staff explained that these sessions had been beneficial, but there was no formal review of training, to show how this had potentially improved patient care. They did not monitor where and when training had been delivered.

Wards were provided with an end of life resource file which included guidance in symptom management, referral pathways, useful contact numbers and care planning information.

At the last inspection in June 2020, the trust were told they must ensure staff were competent in their roles. This included but was not limited to the use and the completion of ReSPECT forms and the use of syringe pumps. Syringe driver compliance figures supplied by the trust demonstrated compliance at the hospital was 91%.

We told the trust in August 2020, that improvements must be made to ensure that staff were competent in the use of syringe pumps when required. Syringe drivers were used in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010 and had checklists to ensure they were used appropriately. However, we reviewed two copies of syringe driver documentation and saw that these checks were not completed in accordance with the trust standard operating procedure; ‘Grab and go Box for T34 Syringe pumps’. The guidance states that the cannula should be checked every four hours, but records showed checks were carried out between five and six hourly intervals. The trust did not audit syringe driver documentation.

End of life champions were available on some of the wards, but we did not see any evidence of cross directorate working to share learning and best practice. For example, performing last offices, which is the term given to the care after death.

Specific counselling training was provided to some staff in the bereavement team. One of the bereavement staff explained they had completed a ‘Sage and Thyme’ which is a counselling course and is supportive of staff working within bereavement services. But this did not appear to be routinely offered to all staff.

Managers gave all new staff a full induction tailored to their role before they started work and we saw two newly seconded specialist palliative care nurses supported by mentors as part of their induction.

End of life care

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance rates for the end of life and specialist palliative care team was 100%. However, none of the specialist palliative care nurses received clinical peer supervision or received regular clinical competency training reviews.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. End of life steering group minutes were distributed to the team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Systems did not support effective communication between multi-disciplinary teams. For example, specialist palliative care nurses received ward referrals by telephone, patients admitted to the hospital by the hospice were referred electronically and GP (General Practitioner) referrals were submitted through the electronic hospital database. All processes were independent of one another and none of the end of life staff had oversight of all of the patients requiring potential support in the hospital. However, end of life and specialist palliative care teams met each morning virtually, to review referrals Monday to Friday.

Clinical outcomes were not clearly documented, clinical triage was not in place and effective collaborative team working was not measurable due to the lack of clinical care planning. For example, the patients we saw experiencing pain and discomfort were both visited regularly by the specialist teams. In one case the patient was seen six times by the specialist palliative care team but was still experiencing severe pain. It was not documented what the outcome was for the patients, what the goal was to be and when it should be achieved.

Ward staff explained that fast track and end of life discharges were managed by the complex care team. However, none of the staff we spoke with were able to outline the last end of life patients whom were discharged by the complex care team. Data provided by the trust showed, from August 2020 to June 2021, 153 patients were discharged via the complex discharge team at the hospital.

All ward staff we spoke with told us that end of life and specialist palliative care colleagues were visible on the wards and we saw staff working together to share information.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, end of life steering group meetings were not consistently attended by all members of staff. Specialist palliative care nurses explained that they required a laptop to access the meetings and this was not always available.

Mortuary staff were not included in these meetings and explained that they had offered training to support ward staff to undertake last offices, but the training was not implemented.

A local hospice provided out of hours advice and support to staff and patients, however information collated by the hospice was not reviewed by the trust. For example, referral and patient outcome information.

Seven-day services

Key services were not available seven days a week to support timely patient care.

End of life care

The service was still not available seven days per week. Services were only available Monday to Friday, with out of hours advice offered by the local hospice. This was still not in line with the NHS Seven Day Clinical Standards (2017) which states that specialist palliative care should be available at any time of day or night. The trust were aware of this shortfall and this was on the haematology and oncology risk register due to staffing shortages. However, plans were in place to extend the specialist palliative care team availability to seven days, commencing in September 2021.

Mortuary staff did not routinely work at evenings or weekends but were on call and told us they would come in if a body needed to be released during these periods. They told us they could release a body in a timely manner if all relevant paperwork was complete.

Chaplains were on call at evenings and weekends and aimed to respond promptly to urgent requests, however the lead chaplain was currently not available due to sickness absence. Staff explained that there was a recognition with the chaplaincy to expand the staffing and a recent interview had taken place which resulted in the appointment of two additional chaplains equating to 1.5WTE.

Health promotion

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

We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

Staff assessed each patient's health when admitted using the initial assessment documentation.

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, consent was not always clearly documented.

The service had improved practice when carrying out and completing Mental Capacity Act assessments for all patients who were deemed to not have capacity. Mental capacity assessments were fully completed, and decisions made, were consistently documented and had a clear rationale.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Assessment documents included specific reference to capacity and assessment outcomes.

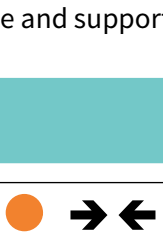
Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. However, staff did not always clearly record consent in patient records. Consent was not included in the 'Caring for adults in the last few hours and days of life' document.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training compliance figures showed 100% for those staff who were identified as requiring this course.

End of life care

Staff could describe and knew how to access relevant policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to articulate deprivation of liberty applications and referral processes to request mental health advice and support.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff did not always treat patients with compassion and kindness, respect their privacy and dignity or take account of their individual needs, there were also issues with caring for patients after they had died.

Staff explained end of life care was provided where possible using the SWAN or side rooms. During inspection we observed patients being cared for in this way. However, families explained staff did not always demonstrate compassionate care and felt that staff did not always have time to support them. The family became upset when staff told them there were 'other patients more poorly' and were not advised when clinical procedures were going ahead.

Another family member explained sometimes basic requests were declined. For example, requests for cups of tea and restricted visiting time, despite the patient receiving end of life care.

One family member explained communication had been an ongoing concern and requested several times for assistance with pain relief for their family member. Another family member told us that there were often lengthy delays in answering the call bell and their family member needing to wait extended periods before analgesic was offered.

However, one patient on ward 8 explained that staff had been 'amazing' and had assisted them to access the garden in the grounds of the hospital. The palliative consultant was described as particular caring and understanding.

Staff did not always understand and respect the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We reviewed the bereavement survey dated May 2021 and saw that 66.7% of patients and their families felt that they had received less support than was needed in dealing with feelings surrounding death.

One family explained that they had not seen the chaplain despite requesting a visit through ward staff.

Last offices were not always carried out for the deceased prior to arrival at the mortuary. Last offices is the term given to the care of the body after death. Mortuary staff explained the omission of this care by ward staff, resulted in patients arriving in an undignified manner. Mortuary staff explained that the impact of this for visiting families was significant and potentially highly upsetting.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress.

End of life care

The end of life team had recently developed complimentary support boxes, which were offered to families at the discretion of ward staff. Boxes contained woollen hearts, drinks vouchers, parking discounts and support and advice. All wards we visited were able to provide these boxes.

Staff explained there were currently no arrangements to enable patients' families to view the deceased in the mortuary. Viewing arrangements had been stopped during the peak of the pandemic by senior leaders of the organisation, and there were no plans in place to review this rule. Mortuary staff explained that viewing had been arranged for one patient as a special request, but it was not clear why this single request had been supported whilst others were declined.

The children's viewing within the mortuary room was not fit for purpose. The room, which was utilised and used as a fridge, was not appropriate for families wishing to spend any time with their loved ones, due to the temperature and noise from the refrigeration system. Mortuary staff explained that it was rarely used as a viewing area as most families chose to visit relatives on the ward.

The bereavement survey dated May 2021 showed that 100% of families stated that they were given the opportunity to see their relative, on the ward, after they died.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement team staff told us they were able to support bereaved families as they had received training regarding difficult conversations through Sage and Thyme. However, In the same survey we saw 71% of families felt that religious / cultural and spiritual beliefs had not been taken into consideration, when liaising with the bereavement office staff.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff did not always talk with patients, families and carers in a way they could understand. Two families we spoke with told us communication with nursing staff had been difficult due to language barriers. Some of the ward nursing staff were described as having a lack of 'good spoken English' which made difficult conversations more challenging. Families explained that due to staffing issues they were not offered support with communication.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were encouraged to complete a bereavement survey and feedback was shared at the end of life steering group and fed back to all staff.

Staff did not always support patients to make advanced decisions about their care. Referrals to the palliative and end of life teams were not timely, and early identification was not systematic across the trust. As a result, although those who were identified as needing the support of the team were unable to make decisions and on many occasions, these were late and reactive, rather than proactive.

Is the service responsive?

Inadequate ↓

Our rating of responsive went down. We rated it as inadequate.

End of life care

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisations to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Staff did not have a comprehensive system to identify the total number of patients who could benefit from their services, so did not know the level of unmet need in either the trust itself, or the wider community.

The service did not monitor inappropriate referrals. As a result, the palliative and end of life care teams identified the needs of some, but not all, of those requiring palliative or end of life care within the community they served.

The service worked closely with the local hospice, relying on their telephone advice line, out of hours, when no specialist hospital team was available. However, they were not working with the wider palliative care community providers to plan care.

The service had basic systems to help care for patients in need of additional support or specialist intervention. The specialist palliative and end of life care teams relied on wards to make referrals to them, supported by an electronic system which flagged up patients in the very last days or hours of life. This system did not identify all patients who were receiving palliative or end of life care, and teams felt they would not be able to meet demand if it did. However, once patients were seen by the team, they were able to refer to other specialist support such as speech and language, physiotherapy and dietitian services.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards where people received care towards the end of their lives could access dementia and mental health champions.

There were end of life champions based on some wards, but they did not link up with each other to share learning or provide peer support. Staff explained they had plans to make the end of life champion training more structured and build in more support.

Staff equality and diversity training levels were at 84%, which was below the trust target of 90%.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents which were well completed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service did not provide information leaflets available in languages spoken by the patients and local community but could access translation facilities when needed. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

End of life care

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff explained there were no restrictions placed on friends or families wishing to visit those receiving end of life care. However, this did not corroborate with feedback received from families who told us visiting times were reduced by the length of time families could stay and how many people could visit. Staff explained that where possible, patients would be moved to a SWAN room, or other single room area to ensure that patients' privacy and dignity was maintained, and that friends or relatives had the opportunity to stay with them overnight. This had been difficult to achieve during the last year due to COVID-19, as infection control had taken precedent, but additionally one SWAN room onsite was out of use.

Chaplains visited patients when requested by ward staff. They explained that often this was very late in a patient's illness. There was no electronic system to alert chaplains that a visit was needed. All of the chaplaincy team were Christian; however, they could access external faith leaders in a variety of faiths. A 'dial a chaplain' service, advertised in public places, was innovative but poorly thought through, requiring a member of the public to use the trust switchboard, not easily available to visitors.

There was no separate multifaith room in the trust. Staff, patients and families, following other faiths had found other space to use elsewhere in the trust rather than using the chapel. Chaplaincy staff had not been engaged during this process.

Access and flow

Patients could not always access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death, where known, were not always in line with good practice.

Managers monitored waiting times but could not ensure patients could access services when needed. Neither team provided a seven-day service so patients could always access support when they needed it. The service's monitoring showed that in 2021, the percentage of patients waiting more than a day to access support from the team had risen from 15% in January to 18% in March 2021. We did not see an action plan to improve this.

The end of life team saw an average of a quarter of all patients who died at the Princess Royal Hospital in 2021, which was worse than the Royal Shrewsbury Hospital. As there was no catchall system to ensure they could accurately assess who would most benefit from their input, the team had no way of knowing that the remaining, majority of patients who passed away at the hospital did not need or would not benefit from their care. Additionally, the teams did not have a way of recording patients seen by both teams (potentially duplicating work). Ward staff explained that sometimes a patient could have several visits from both teams on the same day, as care was not co-ordinated.

Managers and staff worked to ensure they started discharge planning as early as possible. Of those patients known to the palliative care team, just over 88% achieved their preferred place of death. However, not all palliative patients within the trust were identified. Therefore the trust could not accurately reflect their achievement of preferred place of death as they only recorded the outcomes for the patients who had been referred to the relevant teams.

Staff planned patients' discharge. Patients nearing the end of their life could be referred to a fast track discharge pathway, with a target of getting a patient to their preferred place within 48 hours. However, fast track discharges were not achieved. We reviewed the last 91 discharges across the trust and saw the average discharge time for the fast-track discharge of patients in receipt of end of life care was just over three days.

End of life care

The service was not following the trust's policy in respect of complex discharges. Trust policy stated that the complex care discharge team, who worked seven days a week, should co-ordinate end of life discharges. However, in practice this was done by the palliative care team, who did not work over the weekend, and as a result end of life rapid discharges over the weekend were rare. This impacted on patient's preferred place of death.

Staff supported patients when they were referred or transferred between services. Partner services receiving patients felt they were well informed, although delays in discharge, usually caused by transport, had led to people not moving between services seamlessly. We did not see an action plan to improve this.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Information was displayed across all areas of the hospital advising as to how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. The policy set out clear timescales for complaint responses and included supporting information for investigations, writing staff statements and meeting the standards required by regulators.

Managers investigated complaints, staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, we requested the last three complaints specific to end of life and palliative care from the provider and saw that all three complaints had not been investigated in accordance with the providers timescales, outlined within the incident investigation policy.

The end of life team had been asked by a carer if the new kindness hearts provided to patients and their loved ones could continue. The team have agreed that kindness hearts will become an integrated part of their practice.

Is the service well-led?

Inadequate 

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

Leadership

Leaders had the skills and abilities to run the service and understood all of the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff spoke positively about leaders and the support they had offered throughout the COVID-19 pandemic. However, mortuary, chaplaincy and bereavement service staff did not feature on the schematic diagram provided to CQC to explain the service's leadership structure, and bereavement services sat under a different management structure. Therefore, the team was not cohesive and there was disconnect within the existing communication systems.

End of life care

Leaders were aware of and could articulate the current issues faced by the service in terms of capacity, and a historical separation between teams which they had plans to address. However, they did not recognise the overreliance on the experience of individual practitioners or the effect their failure to monitor outcomes was having on patients receiving or wanted to access the service. This meant there was a lack of effective oversight of the quality of the service and the impact this had on the patient's quality of care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to underpin this aligned to national priorities. The vision and strategy were focused on sustainability of services, but it was not clear how they would monitor progress.

The end of life care strategy document which included the specialist palliative care team, covered the period 2019-2022. There had been no revisions to timescales or adjustment of aims to incorporate the challenges posed by the COVID-19 pandemic.

The strategy set out six aims, underpinned by sub-statements. However, the aims were unclear objectives, and as such were not clearly measurable, time-limited or focussed. For example “all clinical staff to be able to recognise all forms of distress” and “good communication between all staff” were wide ranging, difficult to measure and it would be almost impossible to show the service’s individual impact towards meeting the objective.

The strategy featured ‘indicators of success’ but these were not tied to aims or objectives, so it was unclear how the service would know that it had improved, and how it would know if it was on track with its aims.

Monitoring of the end of life care strategy through specialist palliative care steering group was unclear, as although there was a standing agenda item titled ‘strategy’ this was not used to record progress against stated aims or flag any areas that were behind schedule.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care but did not always see end of life care as everyone’s responsibility.

End of life care was not a priority on wards. Ward staff were not fully engaged in making dying everyone’s responsibility. This was reflected in the fact that in more than one area, staff did not recognise patients under their care as end of life or palliative, even when prompted.

However, staff within the EOL team told us they did feel valued and respected.

The trust were unable to identify EOL team responses to the staff survey due results for small teams not being published as that would identify individual team responses in a small team, and no other evidence of a mechanism for capturing or identifying the views of the team was provided to CQC.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

End of life care

There were areas of the service which continued to be of concern and had been previously identified during our inspection in 2020.

The trust had developed a memorandum of understanding with their local hospice to provide mutual support with a view to improve both services. However, this was in draft at the time of inspection, and did not contain any detail of how the effectiveness of the agreement would be monitored.

The trust did not monitor its current use of out of hours support provided by external partners and there were no channels of communication, by which to share themes and learning from the out of hours support.

The most recently planned audit programme fails to measure the performance or quality of the end of life care service. An audit plan had been produced for 2021-22. The trust normally contributed to national audits such as the National Audit of Care at the End of Life and planned to do so in future (having briefly suspended over the COVID-19 period). Audits conducted over the previous 12 months and the audit plan for 2021-22 focussed on the implementation of, or changes in practice by, ward staff, rather than any quality monitoring of the end of life team, their record keeping or effectiveness. Therefore, the trust did not measure quality improvements to the service.

Action plans were not implemented even when poor performance or practice had been identified through audit. Where issues had been identified in audits, for example, in the 'compliance with the care after death policy in clinical practice' audit of April 2021, where 63% of deceased patients were transported to the mortuary in an undignified manner, there was no associated action plan, and results were not discussed (or not documented) at the next end of life care steering group in May 2021. Staff delivering the training to ward staff around the importance of good care immediately after death explained that they had been asked to deliver training once which was poorly attended and had not been asked to revisit this.

The governance around the end of life care steering group was inconsistent. A review of the terms of reference for the end of life care steering group took place in early 2020. The end of life steering group met monthly and was generally well attended. However, the agenda did not state who was chairing, whether the meeting was quorate, and had no regular space for mortuary staff to input or provide updates.

Management of risk, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The team did not hold their own separate risk register. Risks for the end of life team were recorded within the oncology and haematology risk register. Two open risks related specifically to the end of life and specialist palliative care team. These included a shortage of specialist palliative care consultant input and a risk that the size of the team was not sufficient to meet the expected patient demand.

Senior leaders knew what the major key risks were for the team and explained what was being done to address this. However, other risks, such as those relating to the cleanliness of mortuary areas and capacity in the chaplaincy team were not stored centrally on the risk register and were therefore not being actively addressed.

Not all relevant staff had received an individualised COVID-19 risk assessment despite working across all wards during the pandemic. In addition, the associated risk of staff becoming ill due to COVID-19, were not included on the risk register.

End of life care

Information Management

The service collected limited data. The information systems were integrated and secure.

The service was not using data to monitor performance or quality. The service did not have any systems to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level and did not work to any key performance indicators. However, leaders explained there were plans to implement both elements. This was a risk to patients as the lack of quality metrics and key performance indicators meant the service did not know, other than anecdotally, whether what it was doing was adding value or improving outcomes for patients.

Engagement

Leaders and staff engaged with patients and families. However, there was no evidence feedback from patients and families was used to improve services. They collaborated with partner organisations to help improve services for patients.

The service had not made improvements to their service despite receiving feedback relating to patients not receiving good care. The trust had continued to gather feedback from bereaved friends and families throughout the COVID-19 pandemic period. Feedback was generally positive, however, in June 2021 30% of people thought their relative was not free of pain in their last days, and 40% felt that their hygiene had not been maintained. These results were not discussed at the end of life steering group and it was not clear what had been done to act upon this feedback.

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

Learning, continuous improvement and innovation

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

Members of the team had been awarded the Dundas medal for their work ‘taste for pleasure’ work using a patient’s favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

During the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

Urgent and emergency services

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff.

Staff used a web based electronic system to book training. We were told staff undertook competency and relevant mandatory training to enable them to support the department. Some topics were delivered face to face and others online. The pandemic had affected face to face delivery of some training modules. Training was staggered throughout the year; this was so that managers could maintain staffing levels in the department.

Most staff received and kept up to date with their mandatory training. The trust provided us with a breakdown of medical and nursing staff completion of mandatory training. The trust provided us with information including 15 mandatory training modules for nurses and medical staff. Nursing staff at Princess Royal Hospital were compliant with the trust target for this training in ten out of the 15 modules. Medical staff were compliant with the trust target for this training in 13 out of the 21 modules. With rolling trajectories to meet the others within the current financial year. Face to face modules of mandatory training had been reduced during the pandemic. The department had a plan in place to increase this training as the pressure of the pandemic was decreasing.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support.

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

Managers monitored mandatory training and alerted staff when they needed to update their training. The emergency department had increased from one education lead to three in order to facilitate and maintain improved access to the training needs of staff. All staff we spoke with identified this had a positive impact on training timeliness.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, staff did not meet the trust target of 90% for safeguarding children level three training. Senior leaders were aware of this deficit and had identified a need to facilitate an increase in available sessions. A large staff recruitment programme had impacted on availability of some training modules for staff already in post and staff were already aware of trust policy and procedure in this area.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A significant improvement in referral rates and simplification of the procedure for referrals had led to an increase in completed documentation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We observed completed documentation in all 28 records; identifying a review of safeguarding for adults and/or children. We also reviewed three records with completed comprehensive referrals to the local safeguarding team.

Cleanliness, infection control and hygiene

The service controlled general infection risk well. They kept equipment and the premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from Covid -19 infection.

All areas were clean and had suitable furnishings which were clean and maintained.

The service generally performed well for cleanliness.

Cleaning records were mostly up-to-date and demonstrated that all areas were cleaned regularly.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff did not appear to be aware of current infection prevention and control guidelines. During our inspection we observed 12 staff members working within the respiratory isolation unit (RIU) who did not

Staff cleaned equipment after patient contact and sometimes labelled equipment to show when it was last cleaned. Labelling was not consistent; however, we did observe items being cleaned.

Patients were not questioned on arrival in the department in relation to their Covid-19 status and patients were not routinely tested until a decision to admit had been agreed. This meant that patients and relatives were in the department with an unknown Covid-19 status. Children were not routinely tested, and staff did not appear to consider children to be a possible Covid-19 risk. Several children were seen with respiratory illnesses. None of these were questioned with regards to Covid -19.

PPE compliance had also been highlighted to staff during a trust audit in June 2021, where it was noted staff in two areas of the ED did not wear gloves or aprons when within two metres of patients.

These serious concerns were raised with the trust during our inspection and immediately afterwards in writing. The trust produced an action plan which offered assurance that these concerns were to be addressed immediately.

Environment and equipment

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

Patients could reach call bells and staff responded when called. However, call bells and pump alarms were often left alarming despite staff being aware intravenous fluids or medications needed changing. We observed three staff during the inspection identify appropriately that changes were required without silencing the alarm. This could cause distress to patients due to the noise.

The design of the paediatric environment did not follow national guidance. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was not being followed. Children waiting to be seen by the triage nurse were required to wait in the main adult waiting area. During periods of peak activity, nursing staff reported it was not unusual for children to wait up to one hour before being seen by the triage nurse. There was a dedicated waiting room for children. However, this appeared only to be accessible after triage. This meant that children were mixing with adults in the general waiting area for, on some occasions, long periods of time. The children's waiting room was also not available to anyone over the age of 13.

All staff we spoke with in the department were aware of this and regularly discussed this with senior leaders within and across other areas of the trust. Whilst the paediatric resus room was private and away from the busy pitstop and minor's adult area, the two paediatric cubicles were housed next too and between adult cubicles. These were under observation by staff whilst we were in the department. However, children and their parents were in the presence of, on occasion, inappropriate adult patient behaviour. Staff we spoke with did express concerns regarding this and said they would report any incidents of an untoward nature in view of any paediatric patients.

Compliance with national guidance relating to the provision of a safe environment for patients presenting at the ED with acute mental health concerns had improved. The trust had adapted a room which complied with the July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care standards which recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. The room had two means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observation of patients and lighting was adjustable to allow patients to get rest.

It was noted at our last inspection that the mental health assessment room was not meeting required standards due to unsecured furniture being present. We observed the room on three occasions during our visit, one directly after a patient had been transferred. There were no items present that could have been used as projectiles to cause harm to patients or staff. The room had been risk assessed including a ligature risk assessment. Staff did identify the room would be better located in an area with more space due to the increased number of staff needed for patient observation, sometimes including police officers, security and clinical staff. There was only one toilet for the eight majors' patients and any patient in the mental health room. This had also been risk assessed for ligatures and patients were closely observed when using the facility according to an individual patient risk assessment.

Due to bed capacity challenges at the trust, where patients had on previous inspections been cared for on corridors, they were now cared for in the ambulances they were conveyed in. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by a paramedic whilst waiting for transfer into the ED. In order to mitigate patient risk, we observed patients being reviewed on arrival by the ED consultant and or navigator to assess patient acuity. We witnessed a fast positive, (possible stroke), patient be reviewed for thrombolysis (treatment to dissolve dangerous clots in blood vessels), intervention in order that a delay did not occur for treatment if required. The

senior leadership team performed harm reviews on patients held in ambulances over 30 minutes in order to identify any unknown risks or incidents. We witnessed a patient arrive that urgently needed a hospital bed. The staff in ED immediately organised an extra bed in resus to accommodate the patient. Completed harm reviews had not identified any patient harm as a result of ambulance handover delays.

We spoke with paramedics during our visit who all told us they would escalate any patients immediately if any sign of deterioration was noted. During our inspection we witnessed eight ambulances holding patients outside of the department. Patients we spoke with said that whilst the wait was not ideal, they felt safe knowing they were being monitored by a health care professional.

Staff within the department were constantly reviewing and expediating transfers out. However, patient numbers arriving at the ED were in excess of the bed numbers available throughout the trust.

The service had some suitable facilities to meet the needs of patients' and families. For example, during a previous inspection, privacy and confidentiality had been a concern at the patient reception. This had now been changed in order to offer a greater degree of privacy for patients when giving personal details.

Staff carried out daily safety checks of specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis trolleys. All were checked as per the trust policy and included all relevant equipment.

Electrical equipment had been safety tested in the department; this was on a rolling programme.

The service mostly had enough suitable equipment to help them to safely care for patients. However, staff we spoke with expressed concern that the arterial blood gas machine in the adult resus area was out of order on regular occasions. During our visit we witnessed an out of order sign on it three times. This could reduce the access to timely blood gas analysis. One member of staff was allocated to ensuring the regular functioning of the machine however, when they were out of the department or busy; repair or resetting of the machine could be delayed.

Staff mostly disposed of clinical waste safely. However, we did witness one occasion where clinical waste was not removed safely from an isolation area. This was raised with staff during our inspection and was subsequently addressed.

Needle sharp bins in the department were not over full (more than ¾ full) and the bins were dated and signed by a member of staff, (as required by the trust's policy).

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

National guidance relating to the initial assessment of patients who presented at the emergency department (ED) was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. At the time of the inspection six out of fifteen patients we observed waited more than 15 minutes for an initial assessment by the triage coordinator. This

correlates with the data provided by the trust for June 2021 when 45% of children were reported to have been triaged within 15 minutes (with an average of 21 minutes) and 40% of adults (with an average of 30 minutes). However, we did observe a patient bypass triage and be allocated immediately into the minor's area due to nature of their illness. Increased attendances and acuity had impacted on the delivery of improved triage times.

The severity and risk level of the patient's condition was determined by their presentation and the outcome of the triaging tool used in triage area This reflected the order in which patients were seen by a clinician. Patients received an initial assessment by a band six triage nurse. Once seen they were streamed to the most appropriate area for diagnostics or treatment. The initial assessment included appropriate investigations that would assist clinicians with a diagnosis and treatment. Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. During busy times, staff reported clinicians would go out to the ambulance to review the patient if paramedics raised concerns about the patients' conditions. An electronic communication board in the department kept staff up to date with details of any patients waiting in the ambulance. A dedicated nurse navigator reviewed patients who arrived by ambulance.

The department coordinator was a band seven nurse and sepsis leads were identified by a red arm band. During our inspection there were sepsis leads identified from both medical and nursing staff on duty each day as per trust guidance.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a National Early Warning Score (NEWS) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. This ensured early intervention from skilled staff. We checked records and found all 28 records had evidence of NEWS2. Patients were appropriately escalated and treated according to sepsis guidelines in all 10 sets of notes we reviewed for this purpose. The NEWS score was calculated using a handheld device for recording patients' vital signs. This was then available on the department white board for clinicians to see immediately. Increasing the oversight of potentially seriously ill patients.

The department also used the paediatric early warning score (PEWS). The PEWS tool was developed by the Royal College of Paediatrics and Child Health. Staff in all areas completed these observations, including a pain score, in accordance with trust policy, and staff knew the clear escalation process for patients who scored high. However, staff would escalate patients they were worried about even if they did not have a high NEWS or PEWS score.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. For example, we observed patients care being reviewed and reassessed directly after return from x-ray in order to provide treatment for a fractured wrist.

Staff knew about and dealt with any specific risk issues. The assessment booklet contained for example; assessments for sepsis, falls, mental capacity, frailty and skin integrity.

An ED patient safety checklist had been introduced to increase documentation of specific care requirements during a patient journey through the department. The document identified specific tasks that should be assessed during each hour of the patients stay. Including understanding of the care plan, dietary and refreshment needs, pain relief and access to a call bell. All patients note we reviewed had one of these checklists. However, consistency of completion of the document varied. There did not appear to be a specific way to complete them as they were all different. For example; one section asks the nurse to document four things- reposition, call bell, refreshment, and diet. Staff signed against the section but did not necessarily address all four actions. This could mean patients did not receive food or appropriate repositioning for example as the specific task was not always signed for.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). However, direct access was dependent on the time of day between 07:45 and 20:00 support was available with an expected response of one hour, seven days a week. An out of hours cross county service was available outside of these hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. We observed a patient handover for a patient needing a surgical transfer to the Royal Shrewsbury Hospital. We also observed a staff handover between shifts and a whole team board round.

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

Staffing

Nurse staffing

The service mostly had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service mostly had enough nursing and support staff to keep patients safe these were not all trust staff. We reviewed four shift rotas which identified shifts covered with a mixture of permanent and agency staff. During the previous six months the trust had completely reorganised the nurse staffing ratios in order to increase senior oversight and support for all staff. Each shift was coordinated by a band seven nurse with oversight from a departmental matron. This had led to an increase in band six nurses being available to provide care and support to patients and junior staff. We witnessed staffing during our inspection and whilst there were staff shortages due to sickness on one of the days, the second day was fully staffed, according to the off-duty rota. Staff skill mix was monitored to include at least one paediatric nurse per shift. This was complemented by adult nurses that had completed a comprehensive paediatric competency package.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Current staffing requirements were calculated using a recognised staffing tool. The Royal College of Emergency Medicine (RCEM) Baseline Emergency Staffing Tool was used alongside an adapted tool supported by NHS England and ECIST that had formed the foundation for the 2019 workforce review paper. However, the trust had not recently completed a full staffing review. Senior staff we spoke with felt this would be beneficial to ensure accuracy of staffing numbers. The trust identified this was necessary and were planning to complete a full staffing review.

The department manager could adjust staffing levels daily according to the needs of patients. The matron and the band seven had access to the agency booking system in order to book extra staff as necessary for covering sickness and needs according to patient acuity. During previous inspections the department had been staffed with mainly bank and agency staff. This had improved as there had been an increase in substantive staff throughout the department. Shifts were now covered with at least 60% permanent staff and regular agency staff familiar with the department.

The number of nurses and healthcare assistants mostly matched the planned numbers.

Urgent and emergency services

The service had reducing vacancy rates. A rolling recruitment process was in place for adult and paediatric nurses. A further three paediatric nurses were recruited during our inspection.

The service had reducing turnover rates. The introduction of new band seven roles across the department had increased opportunities within the team for development. Leading to increased staff retention.

The service had reducing sickness rates.

The service had reducing rates of bank and agency nurses. However, this could change daily according to staff sickness.

Managers monitored their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with agency nurses that booked block periods of time in the department to ensure continuity for the patients and the team. All agency and bank staff had access to the trust systems and handheld devices to ensure observations could be taken and uploaded in a timely way.

Medical staffing

The service had increased the number of medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service mostly had enough permanent medical staff to keep patients safe. There was a reliance on agency and locum staff. However, these were contracted for regular periods of time.

The trust was commissioned to provide type one and type two emergency care services across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed eight whole time equivalent consultants against an anticipated establishment of 20. This provided four per site. There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies). The department was supported by five further locum emergency department (ED) consultants.

The trust continued not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At Princess Royal Hospital, consultants worked in the ED Monday to Friday between 8:00am and 10:00pm and 9:00am and 3:00pm at weekends. On call consultant cover was provided at all other times.

The trust now had a temporary Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings. However, when this secondment from another trust ended staff were uncertain how the service and improvements would be maintained.

The service always had a consultant on call during evenings and weekends. Weekend consultant cover was by locums only as there were insufficient substantive consultants to cover this period.

There were gaps in the medical rota that the service were unable to fill. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads told us they constantly reviewed staffing to ensure it was both adequate, and as safe as possible.

The service had high vacancy rates for medical staff. There were ongoing plans to recruit new staff and managers had been creative in employing experienced senior registrars to fill consultant roles within the department.

Sickness rates for medical staff reducing.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The locums used were regular doctors who had worked in the service for some time.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There were less consultant staff working in the ED than the England average. In January 2021, 11 % of medical staff were consultants, the England average was 29%. 34% of medical staff working in the trust ED departments were middle career grade doctors, 47% were registrars and 8% were junior doctors. *(Source: NHS Digital Workforce Statistics.)* Managers told us they required 44 middle grade doctors to cover Royal Shrewsbury Hospital and Princess Royal hospital. There were currently 28, dropping to 20 in the following month, due to the middle grades securing training places and promotions elsewhere. The trust department was actively training and recruiting advanced nurse practitioners and emergency nurse practitioners to support junior doctor roles.

Records

Staff kept records of patients' care and treatment however these were not always complete. Records were not always clear or stored securely. However, were up-to-date, and easily available to all staff providing care.

Patient notes were mostly comprehensive, and all staff could access them easily. However, notes were not always organised to prevent loss of individual documents. We observed loose documents within all sets of notes. This could lead to loss of vital patient records.

In each set of notes we looked at, entries were not always signed and dated with staff designation and name stamp or capital letters. There was also no signature legend available. Errors in medical notes were not crossed out according to General Medical Council guidance. (Good Medical Practice 2013). Matrons completed documentation audits as part of the department audit programme. However, they did not appear to correspond with the notes that we reviewed.

Staff acknowledged loose notes were an ongoing problem and whilst they had plans to add new sheets to the current proforma these had not been actioned as the department was awaiting a transfer to electronic notes. They were not aware of a timeline for this.

Whilst records were stored securely. The trolley slots were not labelled with patient identifiable information. This meant that staff were reliant on identifying patients notes through use of bed allocation. Whilst staff caring directly for the patients mostly knew patient names not all visiting staff did. We observed two doctors unable to locate a patient's notes as they were not in the expected trolley slot. This was compounded by the fact the doctors did not know the patients names they were coming to review. This meant they may have chosen incorrect notes if they were misfiled leading to a potential delay in diagnosis/ treatment. This was the same throughout the department.

We spoke with staff about labelling of patient bed spaces and the trolley. Staff suggested this was to protect patient confidentiality.

When patients transferred to a new team, there were no delays in staff accessing their records. These were taken with them for direct handover from the emergency department staff.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, systems and processes were not always utilised.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff did not always communicate or seek support from pharmacy especially when there were issues following processes for prescribing. For example, Patient Group Directions (PGD) were in place for nurses to safely prescribe certain named medicines to specific groups of patients. However, this process had been temporarily stopped due to a misunderstanding of using PGDs. This had led to delays, particularly for patients in triage, receiving some medicines. Pharmacy had not been informed and would have been able to provide the correct advice to staff. There was no dedicated pharmacy team working within the emergency department (ED). This had the potential to reduce communication with the pharmacy department and lead to delays in provision of medicines.

Medicines were delivered from pharmacy twice a week. If there were any medicine shortages or non-availability, then pharmacy provided advice regarding alternative treatment options.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Doctors reviewed patient’s medicines on admission which was documented in patients notes and on medicine records.

Staff mostly stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored safely in dedicated secure storage areas. New improved security systems had been implemented which ensured only authorised staff had access to medicines. FP10 prescriptions were stored securely with a robust checking system to track their use. Controlled drugs were stored and recorded in line with policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. However, refrigerators used to store medications were not monitored according to trust policy. We observed 2 fridges in the ED that had high recorded temperatures for several consecutive days in July 2021. Despite the policy identifying staff should record any action taken and report temperatures over eight degrees centigrade to pharmacy for advice this had not happened. We could therefore not be assured all medicines were stored safely. We informed staff of our findings during our inspection. However, this did not lead to immediate action.

Staff followed current national practice to check patients had the correct medicines.

Medicine reconciliation was undertaken by doctors in ED. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The sepsis screening tool was completed and antibiotics for treating sepsis prescribed and administered when appropriate.

Dedicated sepsis trolleys were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Venous thromboembolism (VTE) protocols were in place and completed for all patients seen and when appropriate were prescribed a prophylactic medicine.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents was shared across the trust.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Decision making processes including a mental capacity assessment were in place for staff to follow if a medicine was administered to manage agitation or aggression (rapid tranquilisation).

Incidents

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

Staff knew what incidents to report and how to report them. Staff could provide examples of incidents they had reported and whether improvements had been made as a result.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had no never events in the department.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to tell us about incidents that may influence the care they provided.

Staff reported serious incidents clearly and in line with trust policy. There were seven serious incidents open to the Medical and Emergency Care directorate from March 2021 to June 2021 One of these was relevant to Princess Royal hospital and related to timeliness of computer tomography (CT) scan reporting. This was under investigation during our inspection.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Patient stories were also used within the department to identify specific areas of learning.

Staff received feedback from investigation of incidents, both internal and external to the service.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. This information was fed back after governance meetings as an action for the week at all staff huddles.

There was evidence changes had been made as a result of feedback. After a patient story was heard at the trust board, improvements were planned to provide a trust values and behaviours workshop and the introduction of Civility Saves Lives workshops in September 2021. The workshops were used to highlight the importance of values and behaviours at work and the impact they have on others. A volunteer role was also being introduced into the ED waiting rooms to provide visibility, assistance, and a point of contact for people waiting.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they had access to support through small groups or the wider team depending on the situation.

Managers shared learning with their staff about never events that happened elsewhere.

Safety Performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with colleagues.

The service continually monitored safety performance. Information was recorded twice daily from 10 patient records on both day and night shifts. This information was uploaded into a software system and findings were discussed at the matrons and senior nurse meetings on a weekly basis. This information was then shared with staff through several different routes. For example; private social media groups, department huddles, emails and at handovers.

The safety performance data showed the service where they needed to improve in a timely way. This was further reviewed by a trust wide exemplar tool. Which was displayed for staff to see in the corridor outside majors.

Staff used the safety data to further improve services.

Is the service effective?

Good 

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

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance and staff had difficulty in accessing these. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. Staff of all grades directed us to printed and electronic trust guidance that was not current. For example, diabetic keto acidosis (DKA) guidance dated 2010 and a fractured neck of femur guideline /pathway that had two dates,

so we were unclear if it was current or not. We discussed this with senior members of the team who were aware that some of the guidelines were not up to date and that a new database was in the process of being implemented. This would include all local guidelines and pathways and we were told would be easier to navigate on the trust intranet system.

Staff working in the department daily did not appear to be aware of this and a completion date was not indicated. Whilst staff appeared to be aware of pathways, they could not sign post us to clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions. This meant that new staff may not be able to access them in a timely way.

After our inspection we were provided with the trust pathway for DKA which was documented as having been reviewed in February 2021. However, the guidance was still based on NHS Diabetes: The Management of Diabetic Ketoacidosis in Adults June 2010 this national guidance has since been updated in June 2021.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. New documentation had been introduced which directed staff on managing patients presenting with a mental Health condition. We reviewed five sets of notes for this specific information all of them had the completed documentation and a plan of care. Patients presenting with self-harm and suicidal ideation were given one to one support by security staff and had received all the required mental health assessments, risk assessments and authority to detain. Trust data for June 2021 showed 100% of patients appropriately received a mental health triage assessment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

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

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

Staff did not always fully and accurately complete patients' fluid charts where needed. We reviewed three sets of notes that specifically asked for accurate input and output records. These were not completed to the correct standard. There were no completed calculations of input/output for the whole period the patient was in the department. Food was offered according to the ED patient safety checklist. However, it was not always clear if food had been accepted or declined as this was not always recorded.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff in the department could access this specialist support if required.

Pain relief

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

Staff initially assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, in eight out of the ten records checked, pain scores did not appear to have been re-assessed within 60 minutes of the initial assessment.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded pain relief accurately. However, we did observe one patient given pain relief despite the records identifying an allergy.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included participation in the following Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Assessing Cognitive Impairment in Older Adults
- RCEM Audit: Mental Health (Self Harm)
- RCEM Audit: Care of Children in the Emergency Department

Outcomes for patients were identified from RCEM audits to be showing signs of improvement particularly within care of children in the emergency department. Medical staff said they were continually monitoring the quality of their patient outcomes and followed up action plans to improve standards. For example, a patient improvement action plan that is reported externally. This had identified improvements to:

Standard 1: Infants at high risk of potential safeguarding. All patients are now discussed with a senior prior to discharge

Standard 2: A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen. This is now routine practice and reported externally. We observed evidence of this on inspection.

Standard 3: Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents. If over 16 years of age are assessed by Rapid Assessment Interface and Discharge team (RAID) and if under 16 years of age have direct access to a CAMHS consultant.

Standards 4-6: These are required organisational standards that relate to frequent attenders of the department, potential safeguarding cases and unexpected departures prior to treatment. These are now all covered by Trust policies.

Managers and staff used the results to improve patients' outcomes, and to improve care and treatment. Action plans to improve performance were in place and were updated and discussed regularly within the clinical teams. Junior doctors participated in audit data improvements and this formed part of their clinical education. Band seven nurses led small teams of staff within the department to focus on specific improvements in care including sepsis management, complaints and tissue viability. We observed and reviewed evidence of staffing fully recruited to the department leadership teams as well as Band 6 and 7 nurses, consultant presence in ED between 8am and 10pm 5 days per week, and 6 hours per day on weekends at both sites at least twice daily consultant led Board Rounds. And the introduction of flow coordinators who support early escalation, white board oversight and performance monitoring.

Urgent and emergency services

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Regular local quality audits were undertaken in the emergency department and the results were fed back into the trusts internal quality assurance systems. Externally reported audits were completed as required.

Managers shared and made sure staff understood information from the audits. Audit results were discussed locally within the department, divisionally at quality meetings, and trust wide at board level.

The service had a lower than expected risk of re-attendance than the England average. The reattendance rate at this trust in May 2021 was 6% and 8% in the midlands.

Competent staff

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

Senior nurses were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The department was run by senior nurses who were experience in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses working in the emergency department (ED) were junior or were international nurses who had recently joined the service. This group of staff did not initially have all the necessary skills to meet all patient needs. In order to achieve this there was a comprehensive ongoing training programme to address this. Senior nurses we spoke with told us that each day staff were becoming more confident and learning new skills.

Managers gave all new staff a full induction tailored to their role before they started work. Nurses spoke highly of the induction process which had been developed based on staff suggestions for improvement. They told us it was very thorough, and they were given time to settle into the department and work a supernumerary period before being counted in the nurse staffing figures with suitable supervision and a buddy system in operation. A cohort of overseas nurses had joined the department recently and they had all been supported through an extended induction to ensure they were comfortable with the transition. We spoke with six of these staff and they all felt extremely supported.

Managers supported staff to develop through yearly, constructive appraisals of their work. 85% of ED nurses had an in-date formal appraisal recorded. Although this did not meet the trust target of 90%, staff had access to ongoing one to one support development conversations. Delays in appraisals were largely due to the extra pressures on staff during the Covid-19 pandemic. 84% of medical staff had received an appraisal. Staff told us of new development opportunities that had arisen as a result of the appraisal process. Including support to apply for roles to develop outside of the department which would benefit the trust as a whole.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. A recent restructure of the nursing clinical leadership had encouraged staff to develop into different roles which supported the overall running of the department.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high quality training which covered their learning needs. Feedback from junior doctors about their experience and access to clinical supervision in the department was extremely positive. Staff we spoke with told us they had seen improvements in the department and had decided to stay. A number of medical staff were also now taking up training posts within the region.

The clinical educators supported the learning and development needs of staff. There was a team of three clinical nurse educators to support nurses to maintain and further develop their professional skills and experience. All the nurses

working in the department were allocated into teams. These were led by a band seven nurse and were identified leads for different speciality subjects. They then trained other nurses in that subject or assisted other nurses in caring for patients. There were link nurses for dementia; stroke; cardiology, diabetes, mental health; alcohol; trauma and others. These included cross site staff to ensure both ED's were discussing and sharing the same content. This developed supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conferencing facilities. Team meeting minutes and outcomes or actions were shared with all staff via email, social media or by a dedicated staff app. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.Medical staff told us they received additional specialist training and had dedicated learning time within their rotas. Health Education England (HEE) had recently congratulated the trust on providing excellent training and supervision to junior doctors. There were regular training sessions during handovers and evidence of emergency scenario training sessions for both adult and paediatric emergencies for all clinical staff.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. There was to be a new volunteer role introduced into ED waiting areas to better signpost and support waiting patients.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily huddles around the white board included all disciplines of staff. Leaders described how they worked closely with the medical division to improves medical reviews and access onto a medical ward if required. The frailty team were active in supporting staff and patients in the emergency department (ED), although there were no inpatient frailty beds at the hospital. The team consisted of occupational therapists, physiotherapists and a social worker. Plans were in place for a geriatrician to join the team this summer. Staff told us this was essential to develop the service. Currently the frailty service was only available for limited hours which meant that some patients may be admitted onto wards when they could have been discharged, compounding flow throughout the medical division, particularly at weekends.

Staff worked across health care disciplines and with other agencies when required to care for patients. Medical doctors and advanced nurse practitioners were in the ED regularly. Staff we spoke with informed us that speciality doctors were mostly responsive when asked to review patients they were contacted by the flow coordinator on duty and if there had been no response within the hour it was immediately escalated to the consultant. We observed a number of telephone discussions, (and saw documented in medical notes), with speciality teams that facilitated patients being accepted for admission in order to reduce delays and facilitate timely care for patients. Patients who required admission to the Royal Shrewsbury Hospital had delays in being transferred as a result of transport. However, during our inspection we did observe a patient being transferred from Telford to Shrewsbury for surgical care and to aid the patients a patient swap was organised for some one that required a move from Shrewsbury for on-going care.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service worked closely with ED staff and provided advice and support when required. Staff we spoke with also told us there was to be an increase in access to mental health support and a plan had been agreed to employ registered mental health nurses directly into the ED to provide further support and specialist care for patients without relying on agency staffing.

Seven-day services

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

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

The frailty team was available Monday to Friday and the last referral time was 4pm. The staff we spoke with felt that if the service could be developed and extended there would be a greater reduction in hospital admissions. Staff at PRH were awaiting the arrival of a geriatrician to join the team. They told us that patients attending during the evening and overnight would, by default, be admitted. However, if they had been able to access the frailty team, admission could have been avoided

Occupational therapy and physiotherapy cover for the emergency department (ED) was included in the hospital site therapy rotas and was therefore not dedicated to ED patients, except on a Tuesday morning when four hours was dedicated to ED. Staff we spoke with felt an increase in cover would ensure more timely care for some patients particularly if they were going to be transferred onto wards where they would require therapy. The early access, for example, for stroke patients would potentially ensure patients started any exercise at the earliest opportunity.

We were told staff had good access to imaging 24 hours a day, seven days per week and they were not concerned about any delays in reporting or accessing results.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the emergency department (ED). Leaflets were available and given to patients for a range of conditions and we saw staff signposting patients to other helpful services during triage. However due to Covid-19 leaflets were no longer on racks in the department.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patients physical, psychological and social needs formed part of the ED admissions booklet. Patients were referred to their GP for continuing support if required.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients records we reviewed had evidence of appropriate assessments.

Urgent and emergency services

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some emergency department (ED) nurses had clearly recorded they had sought consent from a patient before carrying out an intervention.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff described how they supported children to make decisions about their care and treatment.

Nursing and medical staff did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data showed 84 % of nurses had completed this training at the time of our inspection. Senior staff told us training was booked on a rolling programme. Medical staff compliance was 86%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Deprivation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The ED monitored its use of chemical and physical restraint and provided an up to date policy and procedure for staff to refer to which included a process chart for ease of understanding.

Is the service caring?

Good ↑

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

Compassionate care

Although individual staff members treated patients with compassion and kindness, the service was not designed in a manner that always respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

Although we found improvements since our last inspection, issues with the environment and patient flow meant patients did not always receive good compassionate care.

Urgent and emergency services

Patients waited longer for staff to attend to their needs and we witnessed two patients shouting out in distress waiting for staff to assist them. However, when staff were available, they showed genuine kindness and compassion holding the patients' hand and trying to calm them with soothing words.

Staff remained discreet and responsive when caring for patients. Staff worked hard to protect the privacy and dignity of patients with use of curtains and screens. Interactions between nurses, doctors and their patients mostly demonstrated kindness and compassion. However, we observed that staff particularly in majors did not always have enough time to spend talking to patients beyond carrying out essential tasks.

Patients said staff treated them well and with kindness. Without exception all patients we spoke with were happy with the care they had received and felt grateful to the staff looking after them. They understood the time it took to gain access to a bed and were grateful to all staff for how hard they were working to keep them safe and comfortable.

Staff followed trust policy to keep patient care and treatment confidential. However, some conversations could be overheard by other patients. For example, a patient had been admitted into the major's area and a number of non-trust staff were able to hear a confidential conversation between a patient and a doctor.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff were non-judgemental when caring for patients with acute mental health conditions. However, the number of security staff and police present presented staff and other patients with space and privacy issues when attempting to access the toilet or medical notes in majors.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they had access to resources on cultural needs and were able to offer these to patients as required. Most patients moved out of the emergency department however, before requiring culturally specific care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state. For example, one patient was concerned for their partners welfare more than their own physical health so staff expediated care to ensure the partner was not left alone for longer than necessary.

Staff supported patients who became distressed in an open environment and tried to help them maintain their privacy and dignity. However, this was not always possible as there was limited facilities available for personal care. We observed one patient admitted in a dishevelled state who was not able to be supported to be cleaned effectively in the department.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There was an end of life support box available which contained resources for families.

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the life changing conditions some patients presented with and discussed these sensitively with patients and relatives.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients were happy with the information provided to them by the clinical team. Plans were explained in detail and in language they could mostly understand. However, patients who were still awaiting a review after triage were sometimes left for up to three hours without any further update. Senior staff were aware of this and were developing a volunteer role within the waiting areas to support patients in accessing further information.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff spoke with patients, families and carers using language they could understand, and communication tools were available if necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about the Friends and Family Test and the hospitals complaints service was available in the department. Although during the pandemic friends and family had not been allowed into the department. This had led to a reduction in feedback overall.

Staff supported patients to make advanced decisions about their care. The ReSPECT form was used in the emergency department to record patient's wishes for their end of life care and included resuscitation decisions and a preferred place of death.

Staff supported patients to make informed decisions about their care. Doctors and nurses explained to patients and their relative's alternatives to treatments where these were available.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service was designed to provide care in a way that met the needs of local people and the communities served. Managers and staff worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of the local population. However, there were challenges within the environment that made this difficult.

Urgent and emergency services

The emergency department (ED) at Princess Royal Hospital was open 24 hours a day, seven days per week. A public consultation (Future Fit) took place in 2018 which confirmed the agreed way forward for the future configuration of clinical services, including emergency services. A Strategic Outline Case was being finalised for submission to regulatory and national bodies seeking approval and funding for the resultant Hospital Transformation Plan.

We found the physical environment was not always fit for purpose. For example, the children's cubicles were adjacent to the fit to sit area and not adjoining each other, the resus room was a large open plan space separated by wheeled partitions which offered limited privacy and no confidentiality, there was limited availability of a safe area to undertake aerosol generating procedures in the event of an emergency in resus . There was a lack of toilet and wash facilities for patients spending long periods of time in the department. Whilst a room was available for mental health (MH) patients it was small and there was no space outside it for security or police officers that may be required. During our inspection we observed two police officers and a security guard in majors outside the MH room. This caused congestion around the toilet area and the only area available for staff to review notes and access the computers. This meant confidentiality could be compromised for all patients in the major's area. However, senior leaders were aware of these problems but were unable to address the issues whilst funding and system changes were waiting to be finalised.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff understood the need to report mixed sex breaches in the respiratory isolation unit (RIU) and reported one whilst we were on site. Mixed sex rules were not applicable to other areas in the emergency department (ED).

Staff could access emergency mental health support 12 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The trust had plans to increase this level of cover and were in discussion with the local mental health the trust and commissioning colleagues.

Patients records showed they had been referred appropriately and had been seen by supporting organisations. Dementia support staff worked in the trust and visited the ED daily to provide support and guidance to staff. The department also had staff champions within the team to support specialist care.

The service had systems to help care for patients in need of additional support or specialist intervention. The frailty team were available Monday to Friday, at present, in ED to provide advice and support to patients who presented with musculoskeletal injuries or who required social support to return home without a prolonged hospital stay. ED staff had access to specialist nurses with a range of skills including tissue viability, sepsis, learning disability and safeguarding.

The service relieved pressure on other departments when they could treat patients in a day. Staff monitored and reviewed inappropriate admissions. They tried not to admit patients unless it was medically required. However, as the frailty team were not available in evenings and weekends it was inevitable that some patients were unnecessarily admitted. The frailty team told us they monitored this across both sites after an additional evening and weekend frailty therapy cover commenced December 2020 as part of a winter pressure scheme the data form this project did demonstrate the impact evening and weekend frailty input can have. There are also out of hours admission avoidance pathways accessible to all front door staff.

We reviewed evidence that the extended frailty project data identified that frailty's input out of hours does increase the identification of patients that could have their admission avoided and also increased the rate of patients going home instead of to step down beds. A further review of 100 patients at each site was planned to commence September 2021 to assess the appropriateness of admission in relation to community services that are available according to day/time of admission.

Urgent and emergency services

Managers and staff worked with other providers to organise care. There was a triage system to enable patients to be treated by the most appropriate service. Some patients were redirected to the onsite GP service for example. ED leaders worked closely with the commissioners and community providers to try and find system responses to the capacity issues both in the ED and the wider trust. The ED leadership team were active in the regional urgent and emergency care group and met monthly with the ambulance service to improve services. As a result they had employed an ambulance navigator within ED to review patients in ambulances. This enabled patients to be assessed and potentially moved into the ED according to their acuity. We observed a patient reviewed by the stroke team and a patient moved into ED after it was identified that they needed a hospital bed.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. However, the department (particularly majors) was noisy as a result of pump alarms not being managed in a timely way and there did not appear to be a quiet space or room that a patient living with dementia could be cared for separately.

We observed several patients in the major's area who appeared confused and were unsupported for long periods of time. We also witnessed; several staff members who were not aware of the patients names they had come to see. When we questioned this, we were told they 'have a lot of patients to see'.

The children's waiting room was decorated with child friendly images on the walls. The area was quieter; and provided privacy from the main waiting area. A baby changing unit and toilet facilities were available to those using this area.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Specialist nurses and department champions supported emergency department (ED) staff to identify methods of assisting these patients. The department had a drawer with items that may be useful for distraction; for example, twiddle muffs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available at reception and staff provided any additional support patients required as a result of their disability.

All printed information leaflets were in English, although staff had access to some online information in alternative languages which they could print for patients. Leaflets and signs in the department were in English which was in line with the local demographic. There was no information available in Welsh, despite the ED being close to the border. Staff we spoke with reported they had never been asked for any information in Welsh.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This was primarily over the phone; therefore, staff reported that if they required alternative provisions such as a British Sign Language interpreter, this could be arranged. We saw that the department had a set of 'communication cards' which were developed by an external company for use by hospitals to communicate with patients. These cards had many images on; for example, a variety of body parts for patients to indicate pain, pictures of procedures to explain what may be undertaken with the patient, and basic symbols for food and drink.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This was mainly sandwiches, plus toast and cereals at breakfast time. However, staff said they could access hot food on an individual basis if required.

Access and flow

People did not always have timely access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. There was a declining picture, consistent with increasing numbers of patients coming into the service, the numbers of patients attending the department had exceeded the number attending each day prior to the pandemic. Patients were not discharged from the department or admitted to the ward in a timely way.

Patients accessed emergency services when needed. However, they did not always receive treatment within agreed timeframes and national targets. Managers monitored waiting times.

The Royal College of Emergency Medicine recommends patients should wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard and performed worse than the England average over the 12-month period from May 2020 to April 2021. In April 2021, the trust reported a median time to treatment of 82 minutes. This was longer than the England average of 57 minutes. The trust's recent performance had improved compared to the same period two years ago, when in May 2019 it was 102 minutes.

The trust's proportion of patients admitted, transferred or discharged within four hours of arrival was consistently amongst the lowest in the region over the two years April 2019 to January 2021. However, there was an increase from 62.6% in January 2021 to 72.9% in May 2021. The midlands regional average was 78.7% and England average 83.7%.

The proportion of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover was higher than the midlands and England averages from 7 March to 27 June 2021. As of 27 June, 19% of patients waited over 60 minutes on the back of an ambulance. The midlands average was 6% and the England average was 4%. There were ongoing discussions with system partners to try to reduce this handover delay. All staff we spoke with were aware of the potential risk to patients in the community. Senior divisional leads felt that now the medical division and the emergency care division were one team they were starting to see small improvements in flow. Although it was too early to note any sustained improvements.

During our inspection, the service was operating under severe pressure and we saw patients had long waits to be seen. This included delays in ambulance handovers, access to triage, and review by a doctor. Capacity in the department was on the emergency department (ED) risk register. There were a number of mitigations in place to try to improve flow. These included two matrons appointed to coordinate the management of patient flow within all areas of the Trust, four daily site safety meetings with senior and clinical ED representation, Patient flow projects including frailty and stranded patients, twice daily clinical board rounds, 2 hourly huddles, daily conference calls with partners to facilitate patient discharge and admission and the introduction of an ambulance handover nurse for 12 hours a day to review patients delayed in ambulances.

On 19 July 2021, the departments compliance to the four-hour target to see, treat, admit or discharge was 64%. In June 2021, the trust wide figure was 68%.

On 19 July 2021, there were four, 12-hour breaches and one on 20 July 2021. In April 2021, the trust wide figure was 12.

Department leads identified numerous on-going actions to improve flow through the department. These included; a continuation of monthly system wide demand and capacity meetings, audit of appropriateness of urgent treatment centre (UTC) usage, a focus session scheduled to include initial assessment from ED to increase opportunities to further stream to UTC and Same Day Emergency care (SDEC) and planned action for paramedic referral to SDEC over the winter period.

Managers and staff worked to make sure patients did not stay longer than they needed to. ED department staff tried to facilitate care as quickly as possible for every patient. A newly created flow coordinator role helped to get patients moving through the department and identify any delays as early as possible. Delays in triage were not displayed so some patients were unaware of how long they could be waiting However, once seen in the department staff made every effort to keep patients and relatives up to date with delays and changes to treatment plans.

ED doctors reported that speciality staff mostly reviewed their patients while in ED as quickly as possible and that there was a memorandum of understanding to ensure this process could be escalated if necessary. We saw a number of patients discussed over the telephone to expediate admissions where possible. For example, patients with a diagnosed fracture could be fast tracked through the department for admission if appropriate.

Escalation processes were in place for staff to follow when capacity in the department began to deteriorate. Reviews of the department were made at least two hourly by the flow coordinator and the nurse in charge. These looked at patient safety and risk for patients in the department and those awaiting offloading from an ambulance and flow through the department to discharge or admission.

The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff we spoke with said “flow was still seen as an ED problem”. Staff felt they were working at level four but did not always feel empowered to take action. We observed an extra bed added to resus and patients being expediated although this did not happen until quite late on in the shift.

Senior staff said they were frustrated at the trusts failure to declare the highest OPEL level.

Following our inspection, the trust provided an action log to demonstrate the actions they had undertaken during this period. They told us they had treated the situation like a level four internally, and provided maximum support internally, despite declaring the situation externally as a level three.

The trust worked to reduce the number of patients admitted to hospital following attendance at ED. In June 2021, the trust admitted 24% of all type one attendances, which was below the England average. This was better than in March 2021, when they admitted 34% of all type one attendances.

The number of patients leaving the service before being seen for treatments was low. The numbers were similar to other trusts both regionally and nationally. There had been a steady increase in patients leaving before being seen since January 2021. However, we saw evidence of follow up of both adults and children being contacted to ensure they were safe.

Managers and staff worked to make sure they started discharge planning as early as possible. The frailty team attended the ED Monday- Friday to assist with discharges. There was a trust wide initiative to free up hospital beds earlier in the

day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order free up hospital beds and obtain access to continuing care for patients who required this. The trust were working with commissioners and community providers to access rapid response teams of nurses who could help patients going home and prevent some admissions. However, at the time of our inspection, this service had not started.

Staff planned patient discharges carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment. However, there was a national shortage of mental health inpatient beds, and this was reflected in the number of patients with mental health needs staying in the department longer than was necessary. We observed one patient who was waiting for an inpatient mental health bed was in the department for more than 50 hours.

Staff supported patients when they were referred or transferred between services. Navigators and triage staff provided information to patients who were referred to other services.

Managers monitored patient transfers and followed national standards. Surgical patients were transferred to other hospitals using recognised safety standards.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. Information was available in the ED waiting areas on how to make a complaint. Complainants received a response from the ED within 20 days of making a complaint. From April to June 2021, there were 27 complaints and three compliments. The department received 10 complaints in June 2021, most were about clinical care and treatment. The time taken for the emergency department (ED) part of the investigation took an average of 20 days from June 2020 – July 2021.

Staff understood the policy on complaints and knew how to handle them. Nurses told us they provided patients with information about the Patient Liaison Advisory service (PALS) if they were unable to resolve a complain at the time. However, nurses said they always attempted to resolve a patient's concerns locally and at the time of the incident.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers. Complaints were discussed at clinical governance meetings.

Recent complaints were mostly about delays to care. Formal complaints were discussed during divisional governance meetings and where appropriate lessons learned were shared throughout the trust.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us they kept the patient and family up to date with complaint progression as soon as they were able. Managers were allocated administration time in order to respond to complaints.

Urgent and emergency services

Staff could give examples of how they used patient feedback to improve daily practice. This included feedback from the patient volunteer group and local Healthwatch who had made suggestions to improve the environment in ED following feedback they had received from patients. The decision to have volunteers within the waiting rooms and enhance staff values and behaviours training had also come from patient feedback after a patient story to the board.

Is the service well-led?

Requires Improvement 

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

Leadership

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

The Emergency Centre was managed under the Medicine and Emergency Care division and was run by the Divisional Medical Director and Divisional Director of Operations. The leadership structure in The Emergency Centre side of the division consisted of a Clinical Director, Centre Manager, and Divisional Director of Nursing and Divisional Deputy Director of Nursing. The nursing team were led by a matron who was supported by a team of band seven nurses who took charge of the daily operational running of the service.

Local leaders we spoke with were clear about their own roles and accountabilities, although some staff said they believed the trust wide leadership team were not always fully sighted on the issues faced by the department or fully aligned with the departments view on finding solutions. For example, during our inspection the department was under extreme pressure, however managers had not declared a level four OPEL incident. Internal actions had been set in place which were aligned to level four incidents, but the failure to declare a level four externally meant some systems of support which may have been available, had not have been fully explored. From April to July 2021, OPEL level four had been instigated five times, and OPEL level three had been instigated 53 times. We were told this was because the trust did not identify as level four if they still had an intensive care bed available.

Local leaders also felt some frustration that when extra actions were required, these largely fell to ED staff. For example, nurses said some tasks undertaken in ED could be done by nurses working in other directorates, and although nurses were occasionally redeployed to ED to cover a shift, shortages were largely left to the department to absorb through more creative staff rostering and the use of extra bank and agency staff. Staff said there was little visible support provided by other specialities in the trust. This was something the divisional senior team were highlighting across the trust in order to ensure that other divisions were sighted on how problems of flow within ED impacted elsewhere.

Divisional leaders told us they visited the department and spoke to staff during walkabouts. They reported using a ‘’ask five questions’’ methodology, whereby they asked different staff the same five questions to gain an insight into what was happening in the department. Nursing staff told us the nursing and medical leadership team were very visible in the department and that other members of the senior leadership team had recently become more visible. The ED matron was based in the department and supported the daily running of the service.

Urgent and emergency services

There was a band seven nurse in charge every day who had oversight of each clinical area and was required to maintain an overview of every patient in the department. This enabled band six nurses to directly care for patients and support more junior staff in all clinical areas. The career progression this allowed had encouraged several staff to stay in the department as there was now a potential development path.

Vision and Strategy

The service had an emerging vision for what it wanted to achieve and an emerging strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There were seven strands to the strategy. These were; excellence in patient care, leadership, team recognition, wellbeing, professional development, shared decision making and the workforce of the future.

Staff did not talk about this strategy during the inspection; however, it was clear work was underway in some of these areas. For example, the department had recently appointed clinical educators to each site to assist with professional development and had budgeted for each nurse to receive two weeks of training before the end of this financial year.

There was an operational plan which set out how the trust intended to respond to local and national challenges. The plan included improvements in meeting performance such as a reduction in ambulance handover delays and improving four hour waits.

The trust were aware that many of the improvements required were dependent upon external factors, including hospital bed capacity, accessibility of GP services and primary care, and availability of skilled doctors and nurses. The trust were trying to address these issues collaboratively and were active members of the urgent and emergency care delivery group. They worked closely with other providers, 111 services, commissioners and Health Education England in order to realise their strategy.

During our last inspection, one of the trust's priorities had been to reduce the number of patients being cared for in the ED corridor. Although the trust had been largely successful in this area, these patients were still unable to access the service, and were now held on the back of ambulances for long periods of time instead of the ED corridor.

Senior members of the ED department were part of a group who met regularly along with other departmental representatives to discuss the trusts ''getting to good'' plan. This involved identifying actions to each service which would impact on the safety, quality and effectiveness of the care they provided.

Culture

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

All staff we spoke to said they felt respected, supported and valued, and that communication in the department had greatly improved. In our previous inspection, some staff reported a bullying culture from senior leaders however we did not hear that during this inspection. CQC received a written allegation of bullying during our inspection although matrons told us they were not aware of any allegations of bullying in the department. Nurses told us they were aware of how to escalate concerns around bullying and they were aware of the trust's freedom to speak up guardians.

Urgent and emergency services

Governance

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

There were opportunities to meet, discuss and learn from the performance of the service. Clinical governance meetings were regular, well attended and covered a wide range of issues including for example, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff at all levels of the department and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. Staff of all grades directed us to printed and electronic trust guidance that was not current. We discussed this with senior members of the team who were aware that some of the guidelines were not up to date and that a new database was in the process of being implemented. This would include all local guidelines and pathways and we were told would be easier to navigate on the trust intranet system.

Staff working in the department daily did not appear to be aware of this and a completion date was not indicated. Whilst staff appeared to be aware of pathways, they could not sign post us to clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions. This meant that new staff may not be able to access them in a timely way.

After our inspection we were provided with the trust pathway for DKA which was documented as having been reviewed in February 2021. However, the guidance was still based on NHS Diabetes: The Management of Diabetic Ketoacidosis in Adults June 2010 this national guidance has since been updated in June 2021.

Lessons learned from incidents and complaints were discussed in the department newsletter and formed part of the junior doctors teaching. Some junior doctors told us they were not aware of incidents and complaints.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They identified some relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid compromising the quality of care. Some risks were not always escalated.

The risk register contained identified risks and a latest review date, a record of when the risk was added to the register with a clear audit trail with the history, monitoring and updates recorded for each risk through the trust's risk management system.

Not all risks were listed on the register. For example, in June 2021, the department meeting minutes identified a risk to adult mental health patients as a result of limited or no availability at the 136 suite. This had been escalated and alternatives across the system were to be considered. However, there was a risk to patients being managed within the emergency department for long periods of time. During our inspection one patient was in the department for in excess of 50 hours.

Senior staff had identified that mandatory training figures were not reaching the trust target of 90%. This was compounded by the pandemic and the intensive support /training of new staff members. So, although this risk was known it was not identified within the department risk register.

However, staff were able to articulate what the department's main risks were, particularly patient flow and staffing. These were discussed in detail at department governance meetings and minutes were circulated and fed back to teams through other team meetings and huddle debriefs.

We reviewed the department escalation policy for managing increased admissions at times when

demand exceeds capacity. Whilst the policy was comprehensive, staff did not always feel empowered to implement any considered actions early enough in the day. This meant that escalations were made late in the day which negated the chance of further discharges taking place from wards as care home capacity would be limited and frailty reviews were unavailable. The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff we spoke with said "flow was still seen as an ED problem". Staff felt they were working at level four but did not always feel empowered to act.

Data from the trust showed that emergency department co-ordinators; band seven nurses, who ran the department day to day, maintained daily shift logs for both day and night shifts. These logs highlighted issues of performance breaches, staffing concerns (nursing and medical) and how these were managed and any other unusual events, or events which had impacted upon performance. This ensured all staff were aware of ongoing day to day issues and concerns.

The trust had agreed local improvement plans with local commissioners. It was agreed that achieving the four-hour time for 95% of patients was unattainable, and that the trust trajectory should aim for 85% instead. In June 2021, the trust was achieving 68%, which was below the 71% from the previous month.

Information Management

The information systems were not integrated, and staff could not always access patient data when they needed it. The service collected some pertinent data and analysed it. Data or notifications were consistently submitted to external organisations as required.

The emergency department (ED) used both paper and electronic records to care for patients. Paper records were scanned so they were accessible if a patient returned to ED or if information for contacting a patient was required; for example, if they had left the department prior to treatment.

Data was collected to measure performance using several IT systems. Included in this were the time from arrival to treatment, overall time in the unit and outcome such as discharge, transfer and x-ray results. However, patients that left without being seen was captured on paper. We were able to review this documentation which was complete during our inspection and for the two previous months. We were not aware of any plans to implement a change to this method of data collection.

The department had an electronic dashboard showing patient information for the staff. This was used so staff could identify, at a glance, the patient's time in the department and patient acuity. It also identified decision to admit information and patient flags; for example, diabetes and frailty.

There was a secure electronic incident reporting system that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken. Staff had access to policies and procedures via the trust secure intranet. However, these were found in multiple different storage locations and were not easily found.

Patient observations were recorded electronically, however, currently all other documentation was paper based. The trust were in the process of an electronic documentation roll out. Staff in the ED were not aware of any dates for this implementation. This meant that paper assessment booklets had extra sheets slotted into them which may be lost or misplaced. Prescriptions for medicine were paper based, and this led to some delays in prescribing medicines and arranging for medicines to be ready for patients to take home.

There was a performance dashboard which monitored quality audits and which the ED leaders had access to. This information was printed and displayed in the department for all staff to see. Band seven nurses were leads for the performance audit areas and had a team of staff that would champion the specific areas to share best practice news and encourage colleagues to improve certain aspects of care according to patient requirements.

Guidelines were not all stored in the same place on the trust intranet and there was an issue with version control for printed versions of some documents. ED leaders were aware of these issues and said there was a working group set up to manage this. A prototype of a new ED intranet page was about to be tested and this contained links to all relevant guidelines. There was no timescale for final completion.

We were told the trust were working on a system to display waiting times electronically. This would particularly benefit the patients in the waiting area. There were also plans to introduce an ED volunteer to assist and signpost people while they were waiting.

Engagement

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

Leaders told us they engaged with patients through Healthwatch and through their patient volunteer networks. However, due to the COVID-19 pandemic, there had been limited opportunities to engage with patients.

Emergency department staff said they tried to encourage patients to give feedback and to complete friends and family surveys but the demands in the department regularly meant this type of activity could not be undertaken.

Some staff in their band seven teams would deliver a learning session and delivered training to colleagues and had notice boards dedicated to a topic in the staff room. There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade. Staff were also keen to identify changes that would improve patient care and safety. For example, a reconfiguration to the care of children in the department to ensure closer monitoring in an area separate to the adults. This, however, would require finance agreement. There was a closed social media group for staff to share ideas for improvements.

Urgent and emergency services

Learning, continuous improvement and innovation

Staff were committed to learning and improving services, although high demand in the department meant there was not enough time dedicated to improvement initiatives and outcomes. Some quality improvement methods were used, and staff were learning to implement these. While staff were focussed on performance, there was little time for innovation.

Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

The department's new nurse staffing structure, which included a dedicated, on site matron, more senior nurses and three clinical educators across both sites allowed for greater monitoring, oversight and training opportunities.

However, high demand for services, increased requirements for nursing and medical staff, difficulty in consistent recruitment, reduced patient flow and a poor physical environment had meant some of the quality improvements required would take longer to complete. However, without exception all the staff we spoke with working within the department were fully committed to continuing what they described as a "journey". Everyone had a great sense of pride and achievement with how far they had come since our last inspection.

Some of the new pathways and initiatives were still 'a work in progress'. For example, the SDEC (same day emergency care),was still embedding new processes and identifying improved patient assessment pathways to reduce admissions, and the frailty assessment team helped ensure reduced admissions for elderly care patients quickly, it was not available seven days per week.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service ensured most staff completed mandatory training in key skills.

Most nursing, midwifery and medical staff were up-to-date with their mandatory training. However, the number of staff who completed it did not meet trust targets. As at July 2021, nursing, midwifery staff and medical staff overall training compliance rates were below the trust target of 90% at 86% and 82% respectively.

Due to nursing, midwifery and medical staffing challenges in the maternity department, staff were sometimes unable to be released to conduct their mandatory training. Staff could access mandatory training in several ways including online e-learning and face-to-face socially distanced sessions.

The service mostly conducted weekly obstetric skills and drills training on all areas of the maternity unit. However, staff did not carry out skills drills training in the antenatal clinics or in any part of the maternity unit, particularly the post-natal ward which was not always fully staffed with midwives at night. This meant staff may not know how to effectively respond to an emergency in the antenatal clinic or be able to identify any gaps in emergency provision at night.

The mandatory training was comprehensive and met the needs of women and staff. Maternity and medical staff attended a multidisciplinary training course, which covered an annual PRactical Obstetric Multi-Professional Training (PROMPT) style 'skills and drills' training. For Practical Obstetric Multi-Professional (PROMPT) training, completion rates were high for consultants, midwives and women support assistants. As at July 2021, 98% of midwives and 94% of consultants had completed PROMPT training which was above the 90% trust target.

Staff completed annual 'K2' online training to assess staff competency to interpret cardiotocography (CTGs). Cardiotocography (CTG) measures a baby's heart rate and monitors the contractions in the womb (uterus). As at July 2021, 92% of midwives and 94% of medical staff had completed their CTG interpretation assessments. This was higher than the trust target of 90%.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff attended learning disability awareness training days to improve their knowledge of supporting women living with additional learning needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. The education midwife monitored staff training completion and arranged staff training sessions. The clinical governance boards in each area of the maternity department displayed the current staff training compliance rates and encouraged staff to continue to check when their own training was due.

Senior staff discussed training compliance rates and future training plans at monthly training faculty meetings. Additional virtual training sessions had been arranged during the pandemic to enable staff to complete some training from home to try to increase training compliance rates. However, the maternity education team lacked some staffing capacity and space to conduct larger training sessions. This impacted on the number of training sessions that could be arranged. The service was supported by the trust's leadership team to increase the staffing establishment for the maternity education team to address this. The education building was available for some larger training sessions however, the service was also reviewing other suitable training venues.

Safeguarding

Not all staff were compliant with the most up-to-date safeguarding adults training Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Despite this, staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most midwives and women's support assistants (WSA) had completed safeguarding training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff mostly received training specific for their role on how to recognise and report abuse. As of 1 July 2021, the trust's 90% training completion target for safeguarding adults and children training was met for nursing and midwifery staff for five of the six required modules. Safeguarding children training rates for nursing and midwifery staff were above the trust target for all levels with safeguarding children level 1 at 100%, level 2 at 97% and level 3 at 91%. Training compliance rates for safeguarding adults level 1 was at 97% and safeguarding adults level 2 at 96%. However, training compliance rates were below the trust target for safeguarding adults level 3 training at 36%. This training became mandatory for nursing and midwifery staff in February 2021. The safeguarding midwife had increased the frequency of virtual safeguarding training sessions to increase the safeguarding training rates throughout the forthcoming year.

As at July 2021, most nursing and midwifery staff had completed Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Mental Health Act training with training compliance rates at 87%.

Medical staff had not received some training specific for their role on how to recognise and report abuse. As of 1 July 2021, the trust's 90% training completion target was not met for medical staff for three of the six required modules. Safeguarding adults' level 2 compliance was at 81% and safeguarding children level 3 was at 89%. No medical staff had completed safeguarding adults' level 3 training as required in line with the safeguarding intercollegiate guidance. This states clinical staff working with adults who could contribute to assessing, planning and intervening and evaluating the needs of an adult should be trained to safeguarding adults at level 3. A recent external safeguarding review had identified all medical staff should be trained in level 3 adult safeguarding. The clinical leadership team had agreed that this training along with MCA and DoLS would be included in the next clinical training cycle. The first training event was scheduled for September 2021 as part of the rolling training programmes conducted on a bi-monthly basis.

As at July 2021, medical staff training compliance rates for the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act were significantly below the trust target of 90% at 59%. This meant medical staff may not have current knowledge of the Mental Capacity Act, Deprivation of Liberty Safeguards and the Mental Health Act to ensure they apply them appropriately. However, medical staff training compliance rates were above the trust target for safeguarding adults' level 1 at 93%, safeguarding children level 1 at 96% and safeguarding children level 2 at 96%.

Some nursing, midwifery and medical staff had not received PREVENT awareness training to inform them how to safeguard vulnerable people from being radicalised into supporting terrorism or being terrorists themselves. As at July 2021, PREVENT training compliance levels for nursing, midwifery and medical staff were just below the trust and

national target of 85%. For PREVENT level 1 training, 89% of nursing and midwifery staff and 59% of medical staff had completed this training. For PREVENT level 3 (WRAP) training, 83% of nursing and midwifery staff and 52% of medical staff had completed this training. This meant some staff may not recognise the signs of vulnerable people becoming radicalised and take appropriate action.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The named safeguarding midwife advised and supported staff with safeguarding concerns. They worked together with the trust's safeguarding team and external agencies to safeguard women and babies. Staff gave examples of when they have had escalated concerns to protect women and babies from avoidable harm and abuse.

Staff described the trust's midwifery safeguarding team as visible and they helped staff to raise concerns. However, as the maternity safeguarding team were part of maternity services, they were managed by the director of midwifery (DoM). This meant they were not always aligned with the corporate safeguarding team, particularly with the children's safeguarding team, to ensure they all had a coordinated approach. This team was due to move to the trust's corporate safeguarding team to mitigate this as this was a recommendation from an external maternal safeguarding review.

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

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

Staff followed safe procedures for children visiting the ward. All visitors to the maternity unit, apart from partners were limited in accordance with the trust's COVID-19 restrictions response. However, staff were aware of the risks to children when able to visit.

Staff followed the baby abduction procedures in the trust's new-born security policy. The service used an electronic baby tagging system to alert staff if a baby was attempted to be removed from the department. Staff regularly tested the alarm system was working effectively.

Staff did not undertake baby abduction drills. Baby abduction drills were not included in the maternity specific 'skills drills' scenario training. This meant some staff may not understand the procedure to follow if a baby was abducted from the unit. The safeguarding midwife told us abducted baby procedures would be included in the next skills and drills courses.

Cleanliness, infection control and hygiene

The service did not always monitor staff compliance with effective infection, prevention and control practices. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

The service generally performed well for cleanliness. Hand hygiene audits were 100% for each month on the delivery suite for the last 12 months. However, some infection, prevention and control audits were not conducted during the pandemic.

Maternity

Training compliance rates for all nursing, midwifery and medical staff were below the trust target of 90% for infection, prevention and control (IPC) training. Despite this, all areas of the maternity department were clean and well-maintained. As at July 2021, overall IPC training compliance rates for maternity were below the 90% trust target at 75%. Low training compliance rates had been discussed at the divisional IPC meeting held in June 2021. Ward managers had been informed where compliance rates needed improvement, with action plans produced to monitor actions taken.

The daily tap flushing schedule for May 2020 to April 2021 showed this had been completed every day on the delivery suite. This is carried out to prevent water-borne infection, such as Legionella from thriving. However, daily flushing compliance was variable on the Wrekin midwife led unit which may increase infection risks. Compliance rates were below 100% for five of the 12 months with compliance ranging from 67% to 87%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff had fully completed cleaning checklists for June 2021 and July 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). From April 2020 to March 2021, there had been no women with signs of wound infection following caesarean section.

Staff and visitors followed additional COVID-19 precautions across the service. Face masks and alcohol hand gel were easily accessible. Staff had their arms bare below the elbows in line with the trust's IPC policy. This ensured staff effectively washed their hands to reduce the risk of spreading infections.

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

Staff complied with social distancing precautions when required. IPC and COVID-19 precaution information for staff and visitors was clearly displayed across the service.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after each patient contact however, equipment was not always labelled to show when it was last cleaned. The use of 'I am clean' labels was inconsistent across all areas of the maternity service which meant staff may not know when equipment needed cleaning.

Environment and equipment

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

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

However, the Wrekin Midwife Led Unit (MLU) did not have an emergency buzzer that was audible outside of the MLU which may have slowed the arrival of the delivery suite staff who will support the MLU staff to continue or transfer care. The service was already aware of this risk when we raised it directly with them during the inspection. They had implemented some mitigations to limit the impact on safety to women and babies which included ensuring staff were aware of the procedures to follow when escalating an incident via the emergency hospital number. This risk had been recorded on the trust's electronic risk recording system but not recorded on the local maternity risk register to ensure the service regularly monitored the actions taken to mitigate this risk in a timely way.

There had been an emergency on the MLU where a baby had a shoulder dystocia and staff needed support through an emergency call out. A shoulder dystocia is a birth injury that happens when one or both of a baby's shoulders get stuck inside the mother's pelvis during labour and birth. Staff had reported a delay with the emergency response for this incident. The incident report highlighted that delays were more likely at night when staffing levels were lower. As emergency drills were not conducted at night, the service was unable to fully assess the impact of having a non-operational buzzer.

The design of the environment followed national guidance. However, there had been a recent incident when the MLU had to be evacuated as part of the ceiling became unsecure. Staff ensured three women were safely transferred to the delivery suite. Senior staff reported and risk assessed this incident appropriately. They arranged for contractors to quickly rectify the problem to prevent recurrence and to allow the MLU to re-open.

Staff carried out daily safety checks of specialist equipment, and weekly checks of emergency equipment which was used less frequently.

The service mostly had suitable facilities to meet the needs of women's families. There was a dedicated bereavement room on the delivery suite for parents to stay following the loss of their baby. This was sympathetically decorated and had facilities for parents to stay overnight to remain close to their baby for as long as possible. There was also a separate entrance so bereaved parents could avoid using the main corridor. However, as the bereavement suite was next to the delivery suite and it was not soundproofed, parents may be able to hear noise from the delivery suite. The Department of Health's Building Note 09-02 – Maternity care facilities (2013) guidance states the maternity unit suite should have in-patient facilities away from the birthing area for use in the event of a bereavement.

The service had enough suitable equipment to help them to safely care for women and babies. Each birthing room on the delivery suite had a rescusitaire (emergency baby resuscitation equipment) and access to digital systems to write labour records. In addition, staff could easily access emergency equipment and blood products which meant there was no delay if a woman required a blood transfusion in an emergency. However, MLU staff did not have access to digital systems in the birthing rooms on the MLU. This meant staff may not have up-to-date records for women, were not recording contemporaneous notes and had to transfer the information from the handwritten notes onto the digital systems when they could access the digital systems.

Staff had access to equipment to remove women from the birthing pools in an emergency. Staff conducted drills to practise this and to gain any learning.

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

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff appropriately used the Modified Early Obstetric Warning Score (MEOWS) to identify if a woman's condition was deteriorating and needed increased observations or immediate escalation to medical staff.

Twice weekly cardiotocography (CTG) meetings were now held to discuss and share learning. A cardiotocography (CTG) measures a baby's heart rate and monitors the contractions in the womb (uterus). Maternity staff reviewed CTG's with consultants and learned from incidents where CTG interpretation was incorrect. Fresh eyes checks were performed every hour for continuous fetal monitoring. The service had learned from previous serious maternity incidents where CTGs had been incorrectly categorised to prevent recurrence.

Staff on the postnatal ward had started to use the Newborn Early Warning Trigger and Track (NEWTT) tool to aid earlier identification of babies that may need additional support after birth.

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

The Triage Assessment Cards in use in the triage unit were based upon the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This is a nationally recognised, published and recommended system to support obstetric triage and ensure a woman is correctly triaged according to her need.

Carbon monoxide screening, which was part of the 'Saving Babies' Lives 2016' initiative had been suspended during COVID-19. This had affected the compliance rates as the average rate of women who had their carbon monoxide reading taken between April 2020 and March 2021 was 19.3% compared against a local target of above 90%. However, as the service had gradually re-introduced screening, rates were now increasing.

Staff knew about and dealt with any specific risk issues including sepsis and venous thromboembolism (VTE). The Maternity department had a sepsis guideline, with the latest version updated in May 2021. Sepsis is when the body has an unusually severe response to an infection. Staff received sepsis training as part of their maternity specific PROMPT training. This included an assessment to test staff' knowledge. Staff involved in the maternity sepsis workstream were updating sepsis screening tools to ensure they were suitable for staff to identify sepsis of women and babies. However, the service was not currently auditing data to evidence they were complying with the recommended sepsis pathway timelines, such as women receiving antibiotics within 60 minutes. Service leads planned to start this audit to monitor the timelines once staff were using the sepsis screening tools. Staff completed VTE assessments in line with service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. The service did not record the overall individual VTE results for each area of the trust, including maternity. However, the maternity observation management part of the electronic record was a mandatory field and ensured every woman had a VTE assessment. Senior staff confirmed VTE monitoring would be included in the revised audit programme.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. Staff could access specialist mental health support for women when needed. A consultant psychologist and a specialist perinatal mental health midwife provided women with psychological support. The service was coordinating with a local mental health provider to support women with mental health difficulties following pregnancy loss or trauma. women with mental health difficulties following explained that the Matern

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff now checked every woman's' risk of domestic violence status during every appointment. This was clearly recorded in the patient records and flagged on the electronic patient record system. Specialist support was available if a woman was at risk of domestic violence and required intervention. The maternity service had links with domestic violence charities to signpost women for additional support.

Maternity

Staff shared key information to keep women safe when handing over their care to others. The service was working to implement the Continuity of Carer care model to ensure women had a named midwife allocated throughout their care. This helped to ensure staff had all the necessary information at each stage of a woman's pregnancy from their initial booking to their babies' delivery.

Staff performed swab counts in theatre and had implemented learning from a surgical never event in April 2020 where a swab had not been removed, to prevent recurrence. Women now wore a coloured bracelet to indicate they had some internal swabbing material present to remind staff this needed to be removed.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery and nursing handover and the multi-disciplinary team (MDT) shift handover meetings. This ensured midwives and medical staff remained up-to-date about all women and babies.

Midwifery and Nurse staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The numbers of midwives and women support assistants did not always meet the planned numbers. Actual staffing levels for all areas of the maternity department regularly did not meet the planned staffing levels despite from January to December 2020 the trust's ratio of births to midwifery staff was 17.95 being significantly better than the national average of 22.31. For June 2021, the fill rate showed midwifery and nursing staffing levels were below planned levels for all maternity areas apart from the delivery suite during the day when the trust reported surpluses for all staff groups for all shifts except non-registered staff working night shifts (92.9%). The fill rate is calculated by comparing planned staffing hours and actual staffing achieved and indicates gaps in staff when 100% is not achieved.

For June 2021, nursing and maternity staffing for all remaining areas of maternity were below planned levels. The antenatal ward daytime fill rates were 84.5% for midwives and 91.0% for non-registered staff and for night shifts the rates were 98.5% for midwives and 86.7% for unqualified care staff. For the postnatal ward the daytime fill rates were 97.0% for midwives and 93.2% for unqualified care staff and for night shifts the rate was 82.6% for midwives and 96.7% for unqualified care staff.

Senior leaders had used a midwifery workforce planning tool to calculate whether there were enough midwifery staff to provide the required level of care to women and babies. On the delivery suite from 29 March 2021 to 21 June 2021, the acuity levels were met for 64.8% of shifts, 20.7% of shifts were up to two midwives short and 4.2% of shifts were more than two midwives short. For the antenatal ward from 1 January to 30 June 2021, acuity was met for 80% of shifts with up to one midwife short for 15% of shifts, and between two midwives to greater than four midwives short for the remaining 5% of shifts. For the postnatal ward from 1 January to 30 June 2021, acuity was met for 59% of shifts, 22% of shifts had up to one midwife short, 11% of shifts had up to two midwives short, 6% of shifts had up to three midwives short and four and above midwives short for the remaining 2% of shifts.

The maternity clinical dashboard showed between April 2020 and March 2021, most women in established labour received one-to-one care, with an average compliance rate of 99.3%. This was above the local target of above 90%. However, 100% of women should receive this in line with National Institute for Health and Care Excellence (NICE) NG4 guidance: Safe Midwifery Staffing.

Maternity

Lower than planned staffing levels were affecting staff morale and reduced the ability of staff to complete tasks such as mandatory training. Staff in the Wrekin midwifery led unit (MLU) often did not take breaks due to having to cover unfilled shifts on the delivery suite or to cover other staff when they took their breaks. MLU staff also felt anxious as they were regularly moved to other higher risk areas of the maternity department at late notice. Staffing levels impacted on students in the department as they had multiple mentors and their training support lacked continuity.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Maternity leaders had completed a staffing paper to highlight the staffing requirements for the department to the trust board. They had a rolling recruitment programme acting to improve maternity staffing levels. They were well supported by the board to recruit new staff. Service leaders regularly reviewed maternity staffing requirements at monthly maternity governance meetings.

The ward manager could adjust staffing levels daily according to the needs of women. Although staffing levels were often lower than planned, managers regularly reviewed and adjusted staffing levels and skill mix to ensure women and babies remained safe. Actions were taken to meet patient acuity in line with the escalation policy. Senior leaders now held twice daily huddles in all areas of maternity to regularly monitor safety and deploy staff to where they were most needed. The escalation policy was followed when there were unfilled gaps in staffing.

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

The service had high vacancy rates. As of March 2021, there were 9.1 whole time equivalent (WTE) band 6 midwife vacancies and 14 WTE band 5 midwife vacancies. These were approximate figures as service leaders were still conducting a staffing review to calculate accurate figures. However, a number of posts had been filled and recruited to in July 2021.

The service had high turnover rates. From July 2020 to June 2021, turnover rates ranged from the lowest rate of 5.9% for healthcare assistants on the delivery suite to the highest rate of 53.8% for sister/charge nurse on the antenatal ward. However, this very high rate may be due to the small staff group.

The service had high nursing and midwifery sickness rates. Staff sickness particularly on the delivery suite, in addition to some staff having to isolate due to COVID-19, and high levels of maternity staff on maternity leave significantly impacted on nursing and midwifery staffing numbers. For the last 12 months, among midwives, sickness rates ranged from their lowest at 4.3% for band 6 midwives on the postnatal ward to the highest sickness rates of 19.2% for healthcare support workers on the delivery suite.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior leaders had introduced incentivised bank shifts between June 2021 and July 2021 to help improve staffing levels until the recently recruited midwifery staff had started their roles.

Managers made sure all bank and agency staff had a full induction and understood the service. The service used regular bank and agency staff who understood the department.

Maternity

Medical staffing

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

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number. For the last six months, consultant obstetric cover was met for all shifts. Junior staff felt well supported and supervised by senior medical staff.

The service had low vacancies for medical staff. As at July 2021 there were two staff grade vacancies which were soon due to be filled.

The service had high turnover rates for medical staff. Over the 12 months from July 2020 to June 2021, there were very high turnover rates for consultants at 4.9% and for speciality doctors at 97.3% although this figure was extremely high due to the small number of staff in this staff group.

Sickness rates for some medical staff were high. From July 2020 to June 2021, the highest sickness rates were for specialty doctors at 7.9%, followed by specialty registrars (3.4%) and trust grade doctor – specialty registrar at 2.3%. All other medical staff groups reported less than 1% sickness over the 12 months.

The service had low rates of bank and locum staff. The service had not used agency consultants in the past six months and used their own consultants to fill gaps in medical staffing provision.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Regular locums were used to fill any gaps in medical staffing who were knowledgeable about the service.

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

The service always had a consultant on call during evenings and weekends. Senior leaders were increasing the resident obstetric consultant cover to 24 hours a day, seven days a week. This was above the medical staffing requirements of this service with between 4,000 and 5,000 births a year.

Records

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

Women's notes were comprehensive and all staff could access them easily. Records were stored securely. Paper records were securely stored in locked notes trollies.

When women transferred to a new team, there were no delays in staff accessing their records. Patient records were a mix of handheld records for community care and electronic for women's inpatient stay. The service planned to move all

records to electronic records beginning in August 2021. Reports would then be able to be produced from the electronic system and staff would be able to communicate directly with GPs. The introduction of the new digital record meant women would be able to easily access their maternity notes and add personalised information and plans for birth to inform their midwife.

Medicines

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

Staff followed systems and processes when safely prescribing, administering and recording medicines. There was a patient centred approach to medicine prescribing. A pharmacist visited the maternity department from Monday to Friday to review prescribing of medicines. There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours. Maternity staff always knew how to contact pharmacy staff for support.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. Patients' allergies or known sensitivities to medicines were documented on all the medicine records reviewed. The trust's pharmacy team provided counselling and support to patients to explain changes in medicines or when new medicines were started to allow them to raise concerns and ask questions. The pharmacist also provided advice on breastfeeding and medicines.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Controlled drugs were stored and recorded in line with the trust's policy. Daily checks were undertaken, and any differences were investigated.

Resuscitation trolleys were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Emergency grab boxes were also available for postpartum haemorrhage, eclampsia, cord prolapse and hypoglycaemia. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Staff could access dedicated sepsis trolleys or boxes for the immediate treatment of sepsis. These were checked each day to ensure the medicines were available and in date and therefore safe to use.

However, three medicines used to assist women with their birth and to prevent excessive bleeding were not stored appropriately on the Wrekin midwife-led unit (MLU). These medicines should be stored in the fridge at a specific temperature to ensure they work effectively. We raised this directly with the midwife in charge on the MLU. They gave immediate assurances to quickly address this with staff.

Staff followed current national practice to check women had the correct medicines. All patients we checked had venous thromboembolism (VTE) assessments checked by a pharmacist and staff appropriately prescribed a prophylactic (a medicine used to help prevent disease) medicine. A recent audit on prophylactic prescribing for VTE within maternity had led to improvements in prescribing.

Where antibiotics were prescribed, we saw evidence that prescribing was in line with national and local guidance. A pharmacist ensured that any queries about antibiotic prescribing were discussed and followed up with the prescriber. These decisions were documented in the patients notes.

Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. Any required changes were highlighted to the prescriber including post-natal pain relief advice.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Any medicine incidents would be reported onto the trust's incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

Incidents

The service had made some improvements regarding their management of safety incidents. Staff mostly recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They were supported by external agencies to ensure the incident reviewing process was thorough and robust. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Most staff knew what incidents to report and how to report them. Staff raised concerns and reported all levels of incidents and near misses in line with trust policy. Staff at all levels could clearly explain how to report an incident on the trust's incident reporting system. However, staff did not always incident report when staffing levels fell below planned levels to provide evidence of how regularly this occurred and what mitigations were put in place. Good practice and positive feedback received from families was now added onto the trust's incident reporting system from February 2021. This ensured positive feedback and learning was communicated directly with staff.

The service did not have any never events in the 12 months before our inspection. The service had one surgical never event in March 2020. Learning had been implemented to ensure swab count checks were performed in theatre to prevent recurrence of a swab being retained.

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

Staff now understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Duty of candour is a regulatory duty that requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff could access the trust's duty of candour policy on the trust's intranet for guidance.

As part of our ongoing monitoring of the service and at the previous inspection, due to the previous inconsistency of the grading of incidents in maternity services at the trust, we were not assured the service had an open and transparent method of incident grading. This meant women and families may not receive an appropriate response and support from staff in line with the duty of candour. During this inspection, we observed a neonatal and obstetric incident review (NOIR) meeting, where a maternity incident was discussed, and staff were allocated actions to complete. All incidents were now reviewed at the NOIR meeting which was a multidisciplinary meeting with midwifery, neonatal and medical representation. This ensured the duty of candour was complied with as early as possible. Staff from external maternity

units joined this meeting which added an extra level of incident scrutiny. Staff now had a clearer understanding of the need to support women and their families to put matters right and to clearly explain what had happened. The service was continuing to review their incident grading process to ensure incidents were graded correctly. This would help to ensure duty of candour was always met in a timely way.

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

The perinatal mortality review tool (PMRT) group included representation from other NHS organisations, to provide external scrutiny and oversight of the trust processes. The service was receiving support from several external organisations in both clinical practice and incident management to provide an additional level of scrutiny.

Staff met to discuss the feedback and look at improvements to patient care. Senior leaders had implemented changes to improve safety for women and their babies in response to learning from incidents. Obstetricians from another NHS trust attended incident review meetings to ensure incidents were appropriately reviewed and graded.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Through our ongoing monitoring of this service, we had identified ongoing issues with incident grading particularly for some tears and when women had heavy bleeding after giving birth.

The service now ensured incidents graded moderate or higher at the NOIR meeting were then escalated to the division oversight group (DOG) meeting. Any incident identified as a serious incident would then be presented at the corporate incident review group. This meant there may be a delay between an incident occurring to it being declared as a serious incident. If a serious incident did not require any further discussion, there was a clear process for a serious incident to be declared without it needing to be discussed at these three incident groups.

However, maternity governance committee minutes for May 2021 stated resources and staffing changes were affecting the management of incidents. This meant there were many incidents awaiting further reviews and associated updates regarding actions.

There was evidence that changes had been made as a result of feedback. However, the incident reviewing process for maternity was still not streamlined and learning was not always gained in a timely way. Service leaders understood this process needed to be more defined and were reviewing it to ensure it was fit for purpose.

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

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service continually monitored safety performance. Staff used the maternity dashboard data to further improve services. The Safety Thermometer is no longer completed nationally and the maternity department stopped this data collection early last year. This was replaced by the maternity survey with all other data monitored on the maternity dashboard.

Maternity

Is the service effective?

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed nine policies relating to the maternity department which were all up-to-date. The service had an effective system to ensure policies and clinical pathways reflected national guidance and were reviewed according to the review dates.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. We observed multidisciplinary medical and nursing handover meetings. Staff routinely referred to the psychological and emotional needs of women, their relatives and carers. During medical and nursing handover meetings we saw ongoing plans of care were discussed which included women's ongoing emotional and psychological needs.

Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women were pleased with the food and drink provided to them in all areas of the maternity unit

Infant feeding midwives supported women with their feeding choice for their baby. Staff stored expressed breast milk and baby formula milk safely. As at July 2021, the breastfeeding initiation rates within 48 hours of delivery were at an average of 74.6% between April 2020 and March 2021. This was above the national target of 68.1%.

Staff fully and accurately completed women's fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians was available for women who needed it. Staff had recorded when women had dietitian input.

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women confirmed their pain was well managed before, during and following labour.

Staff prescribed, administered and recorded pain relief accurately to ensure women received pain relief soon after requesting it. Staff stored ready prepared packs of pain relief medicines and they were available out of hours. They could be supplied through a prescription or using a Patient Group Direction (PGD).

Patient outcomes

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

The service participated in relevant national clinical audits. The maternity service at the Princess Royal Hospital participated in the National Neonatal Audit Programme 2020 (based on data from 2019.) The trust was within the expected range, or better than expected, for all six metrics in the audit that apply to individual hospitals.

The findings from audits were presented at monthly audit meetings.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The current audit programme was limited to reactive audits and Saving Babies Lives Care Bundle audits. However, the service had recently recruited a lead specialist midwife for audit. They were in the process of producing an audit plan for 2021/2022 to be aligned to the planned more streamlined governance processes to enable senior leaders to monitor the outcomes for women and their babies more effectively.

Outcomes for women were mostly positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women's outcomes. The service used the maternity clinical dashboard to report on and monitor a range of indicators for the service. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. This allowed the service to benchmark their performance against other similar services in addition to enabling the service to target reviews and improvements at the appropriate parameters.

The service had a low expected risk of readmission for elective and non-elective care. For the last 12 months, the elective readmission rate for maternity patients was 1.29% (64) and 1.30% (6 readmissions) for non-elective care.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Maternity services did not currently have any outliers. The trust was supported by external organisations to ensure improvements were sustained and became well embedded.

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

Improvement was checked and monitored. The trust had monthly Ockenden Report Action Plan progress meetings to discuss the services' progress against the actions the trust was required to take in response to the findings of the first Ockenden report published in 2020. This ensured the service took the necessary action to ensure the actions were being progressed in the required timeframes. The Ockenden review was commissioned following a letter sent by bereaved families in 2017, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the trust. The government commissioned a review to assess the quality of investigations relating to new-born, infant and maternal harm at the trust. As at July 2021, most actions had either been completed or had clear workable plans to ensure they were completed.

Maternity

Competent staff

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

Staff were experienced, qualified and had the right skills and mostly had the knowledge to meet the needs of women. The education midwife and Professional Midwifery Advocates (PMA) supported the learning and development needs of staff. However, there was limited rotation across all areas of the maternity department. Band five midwives would rotate into different areas of the department however, once they became band six staff they could request to work in their chosen areas for example, antenatal and postnatal wards. There was a perception that more experienced staff were nervous to work on the delivery suite, caring for higher risk women. More junior midwifery staff would be continually moved to the delivery suite where there was high activity. We were not assured all midwifery staff were competent to conduct their midwifery role in all areas of the department as more experienced and specialist midwives may become de-skilled in caring for women on the delivery suite due to remaining in their preferred areas of the department.

Managers gave all new staff a full induction tailored to their role before they started work. Newly trained and staff who had recently begun working in the department were well supported. New midwives had a buddy to support them in their first 12 months of registration and to help them put their midwifery training into practice.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most staff had received an annual appraisal. The trust set a target of 90% completion. As at July 2021, 87% of midwifery staff and 91% of medical staff had received their annual appraisal.

Managers did not always support staff to develop through regular, constructive clinical supervision of their work. Staff did not always have the opportunity to discuss training needs with their line manager and receive support to develop their skills and knowledge. Due to the staffing challenges the department was currently experiencing, it was not always possible for staff to dedicate time to support staff with their supervision work.

Managers now made sure staff attended team meetings or had access to full notes when they could not attend. Senior leaders acknowledged team meetings had not previously been held regularly to fully update staff. They were now more established and the interim Director of Midwifery had begun to hold daily updates with matrons and ward managers.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Less experienced nursing and medical staff were well supported by more experienced staff.

Managers made sure staff received any specialist training for their role. The service had several specialist midwives for example, infant feeding specialist midwife and bereavement midwives. They had completed specialist training to support staff and provided tailored and individualised specialist support to women and their partners. Consultants and midwives had additional bereavement training following the national bereavement pathway.

Managers identified poor staff performance promptly and supported staff to improve. Consultants were clearly assessed on their competencies. Medical leaders assessed the skills and competence of locum doctors to ensure they met the expected standards for the department. However, several maternity staff had been away from work for extended periods and these roles were covered by staff in interim roles.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior leaders held recently implemented twice daily huddles to monitor safety and staff deployment across unit.

Staff worked across health care disciplines and with other agencies when required to care for patients. The department had links with domestic abuse charities to ensure women received specialist support. Midwifery staff understood how to protect women who were at risk of domestic abuse.

Staff referred women for mental health assessments when they showed signs of mental ill health. The service had a specialist midwife who was trained to support vulnerable women and women living with mental health concerns.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. Senior leaders were in the process of recruiting a further six consultants to increase the resident consultant cover to 24-hour cover, seven days per week for the maternity department by December 2021. This is above the consultant cover requirements for a service this size.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Women could also contact an on-call community midwife out-of-hours, particularly if they were booked in for a home birth and had any queries or concerns.

Health Promotion

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

The service had a healthy lifestyles team and relevant information available to women promoting healthy lifestyles and support. Health promotion information was clearly displayed in the antenatal clinic areas. The Personalised Care and Support Plan (PCSP) included guidance for women to stay healthy during pregnancy such as physical activity, healthy eating and smoking advice.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had arranged virtual parenting sessions which included advice on healthy lifestyles during pregnancy as staff were unable to offer face-to-face classes due to COVID-19.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty. However, medical staff may not have up-to-date knowledge of Consent, Mental Capacity Act and Deprivation of Liberty safeguards due to low training compliance rates.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records. Staff gained consent and documented it in patient records including for women having procedures including caesarean sections.

When patients could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions. Midwifery staff were supported by consultants to obtain consent when women lacked capacity.

Staff obtained consent before carrying out any internal investigation or procedures including, caesarean sections.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The service had a teenage pregnancy specialist midwife to support young mothers and to help them to understand all the birth choices available to them.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. However, not all medical staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards and may not have current knowledge about how to apply this in practice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff did not often need to use DoLS in the maternity department however, they were supported by staff with specialist knowledge if they needed to.

Staff could describe and knew how to access the trust policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust's mental capacity and best interest policy and procedures was available on the trust's intranet for staff to easily access.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff closed curtains to ensure they respected women's privacy and dignity particularly during physical or intimate care examinations.

Women said staff treated them well and with kindness. Without exception, during the inspection maternity staff were dedicated to ensuring women and babies received compassionate care. Women and partners confirmed all staff had taken the time to interact with them in a respectful and considerable way, even when the maternity department was very busy.

Staff followed the trust policy to keep women's care and treatment confidential. Staff now ensured women were not identifiable by name on the patient boards in all areas of maternity and specifically on the postnatal ward, so women's information remained confidential.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. During the midwifery and medical handovers, staff were respectful when discussing women with mental health concerns and certain mental health diagnoses.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Women who had previously suffered pregnancy loss were well supported at specialist pre-term clinics and by the bereavement midwives for later pregnancies.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff followed bereavement policies and procedures to support women in cases of stillbirth or neonatal death with additional specialist support provided by a specialist bereavement midwifery team. Staff valued the emotional and social needs of women and their relatives. During the initial phases of the pandemic the bereavement midwifes attended scan appointments with women when requested when partners were unable to attend.

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

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

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The service had a dedicated self-contained bereavement room where staff could take parents to offer them time to come to terms with the loss of their baby. The service had cold cots which allowed families additional time to spend with their baby.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All staff conducted bereavement training with staff attending additional bereavement day training sessions when available. Consultants would usually break bad news to women and those close to them. The midwifery bereavement team were planning to implement the National Bereavement Care Pathway (NBCP) to improve the quality and consistency of bereavement care received by parents after pregnancy or baby loss.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service took part in a project called "Lighthouse" which identified women who required additional and specialist support from a counselling psychologist following any type of birth trauma which included delivery complications and infant loss. Women also have access to a specialist perinatal mental health team, which includes specialist perinatal psychiatrists, and specialist mental health nurses. All maternity staff received pregnancy and infant loss training as part of their mandatory training. The midwifery bereavement midwives worked with the local children's hospice to support and provide palliative care for families.

Maternity

Understanding and involvement of women and those close to them

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

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

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

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women gave positive feedback about the service. The service took part in the Maternity Friends and Family Test (FFT)which asks women to rate their experience as “very good”, “good”, “neither good nor bad”, “poor”, “very poor” or “don’t know”. During the pandemic, data was not collected from March 2020 to November 2020. We reviewed a range of the maternity Friends and Family Tests (FFT) and found scores were consistently over 90% in all areas and generally scored slightly better than the England average.

Staff supported women to make advanced and informed decisions about their care. Staff included birth partners in the planning for the birth and during post-natal care. Staff encouraged women to use the Personalised Care and Support Plan (PCSP) to ensure their preferred birth choices were recorded.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers mostly planned and organised services so they met the needs of the local population. Women were able to attend antenatal appointments at the location which was closest to their homes. However, as the Royal Shrewsbury Hospital and the Bridgnorth, Ludlow and Oswestry community maternity units remained closed to inpatients women sometimes had to travel further to the Princess Royal Hospital to give birth. The service had promoted home births as an alternative option for women. From January 2021 to March 2021, the home birth rate had increased to 1.9% which was above the national target of 1.4%.

Facilities and premises were appropriate for the services being delivered. Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia. The maternity department also had a specialist mental health midwife who was easily accessible to provide mental health support to women.

Maternity

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

Managers monitored and took action to minimise missed appointments. Women received a reminder text message before their antenatal appointments.

Managers ensured that women who did not attend appointments were contacted. Administration staff monitored when women did not attend appointments. They contacted women to offer them another appointment to ensure they were rebooked to attend.

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

Meeting people's individual needs

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

The bereavement room was sympathetically decorated and could be accessed by a separate entrance to the delivery suite. This meant parents did not have to use the same entrance as families taking their babies home. However, the bereavement room was not sound proofed, which meant parents may still hear babies crying.

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. The maternity service had specialist midwives in mental health and learning disabilities to support women.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service had information leaflets available in languages spoken by the women and local community. Staff could provide women with leaflets in an easy read format if required.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. During a nursing and midwifery morning handover, staff were arranging translation support for a woman who spoke limited English. Staff also had access to a telephone interpreting and translation service to support women to fully understand their care and treatment. The service and the MVP had produced a postnatal video to provide pregnancy advice to women and was due to be available in Polish, Romanian, Bulgarian, Urdu and Punjabi.

Women were given a choice of food and drink to meet their cultural and religious preferences. Women confirmed they were given enough choice regarding food and drinks. Staff provided women with hot and cold drinks. The service had coordinated with the local Maternity Voices Partnership to develop The Personalised Care and Support Plan (PCSP) to provide women with a document to record all their birth and health and wellbeing preferences.

Staff had access to communication aids to help women become partners in their care and treatment. Staff could provide easy read and larger print leaflets to women and families to support their understanding of their care and treatment.

Maternity

Access and flow

Women could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could mostly access services when needed and received treatment within agreed timeframes and national targets. Staff monitored and incident reported when women did not attend their antenatal appointments. Staff conducted follow up calls to check the women's wellbeing and to reschedule their appointment for them. However, the Wrekin midwife led unit (MLU) had been closed for 13 days between 31 January 2021 and 16 July 2021 which meant nine women were transferred to the delivery suite and were unable to give birth in their chosen birth setting. Staffing shortages and staff sickness, including staff isolating due to COVID-19 were the main reasons the MLU had to be closed. All three birthing rooms were in use on five occasions between 31 December 2021 and 20 June 2021 which meant women's birth care was transferred to the delivery suite.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women were triaged on admission into the service to ensure they received the most appropriate care and treatment in a timely way.

Managers and staff worked to make sure women did not stay longer than they needed to. Women had several appointments and checks scheduled on the same day to limit the amount of antenatal appointments they needed to attend. However, the pre-term antenatal clinic regularly ran over capacity. This was one factor which had led to a serious incident in early 2021 as a woman could not access the clinic in line with Saving Babies Lives Version 2. This recommends maternity services set-up early pregnancy and pre-term clinics to support women who are at a risk of delivering their babies early. The service had acted on these findings to extend the current capacity by recruiting a new consultant with a specialism in pre-term labour to support the clinic.

Managers worked to keep the number of cancelled appointments to a minimum. When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. The service had strong links with external agencies to ensure women received appropriate and timely support following their discharge.

Staff supported women and babies when they were referred or transferred between services. The services vision and strategy included the roll out of the Continuity of Carer model to ensure women received care from the same midwife or midwifery team throughout their pregnancy. The service was particularly focusing on ensuring women living in deprived areas and women from a Black, Asian and minority ethnic (BAME) background as they may face additional maternity risks.

Learning from complaints and concerns

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

Maternity

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Posters were clearly displayed throughout the maternity department to direct women to the trust's Patient Advice and Liaison Service (PALS) to make a complaint. Leaders of the service tried to alleviate women's and their families' concerns as early as possible to prevent them from needing to raise a formal complaint.

Staff understood the policy on complaints and knew how to handle them. The trust had a concern and complaints policy and procedure for staff to follow.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. We reviewed three recent complaints regarding the maternity service. These complaints were handled effectively to ensure openness and transparency with a timely response, in accordance with the deadlines specified in the trust policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used women's feedback to improve daily practice.

Managers shared feedback from complaints and compliments with staff at team meetings and staff huddles. Each area of the maternity department displayed a clinical governance board which included the number of complaints and compliments received for each maternity area for that month. Staff were aware the main complaints theme for maternity for June 2021 was staff communication.

Is the service well-led?

Requires Improvement 

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

Leadership

Some leaders did not have all necessary skills and abilities to run the service. However, leaders had plans to make improvements and understood the main challenges the service faced.

The entire substantive senior midwifery leadership team were not currently in post. These positions were filled with interim post arrangements which were overseen by the Director of Nursing.

Overall staffing in maternity including midwifery leadership was one of the main risks for the department. This was recorded on the service's risk register as this presented the risk of destabilisation of the maternity service, lack of managerial oversight and lack of leadership of the midwifery team.

The service had proposed a temporary maternity service structure to provide some stability for staff before the permanent organisational structure could be implemented. The permanent structure was in line with the Royal College of Midwives (RCM). The new senior management structure included a consultant midwife and matron for quality and safety to further strengthen the governance structures. The maternity leadership team could describe the structure they were working towards however, due to the current instability of the senior midwifery leadership team, there was no proposed deadline for this to be implemented.

Maternity

Service leaders were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The interim Director of Midwifery had started weekly team meetings and focus groups with staff. Staff now felt more engaged with the leadership team however, staff stated further improvements with engaging with midwifery staff at all levels was required to ensure they were kept fully updated.

The service now had two maternity champions. They met regularly with the trust level safety leads to escalate locally identified issues. They also conducted safety walkabouts of the department. The service had introduced new models of service delivery including Continuity of Carer. The service had recently secured funds for Continuity of Carer forward planning needed to ensure this model could be further developed without affecting current staff levels elsewhere in the department, particularly in peak annual leave periods.

Vision and Strategy

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

The maternity service had a vision and workable plans to turn it into action developed with the involvement of women, and the local community. The services vision and strategy included the roll out of the Continuity of Carer model to ensure women received care from the same midwife or midwifery team throughout their pregnancy.

The service engaged well with women, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The service worked with neighbouring trusts, clinical commissioning groups, other stakeholders, and service users to establish Local Maternity Neonatal System (LMNS), in line with national maternity recommendations.

Culture

Staff did not always feel respected, supported and valued.

Managers were trying to implement change to improve the culture in the maternity department however, they had not effectively engaged with all staff and particularly junior level staff. This meant some staff did not fully understand the proposed new structure and share a common purpose with the leadership team based on shared values.

Staff from other areas of the maternity unit did not always feel valued by delivery suite staff. There was sometimes no acknowledgment that they were supporting them to keep women and babies safe by increasing staffing levels on the delivery suite. Some staff felt unsupported and did not always have breaks due to covering other staff to have their breaks on the delivery suite. This was recorded on the maternity risk register.

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

Maternity

Staff were passionate to provide the highest levels of care to women and their babies. Senior maternity staff praised staff for their resilience particularly in response to the ongoing leadership changes in the maternity department, the high levels of external scrutiny of the department and continuing staffing challenges.

Staff understood how to access the trust's freedom to speak up guardian and ambassadors to raise concerns about the maternity service. They felt able to use this service without fear of repercussions. Some staff had previously left the maternity service and returned due to enjoying working at the trust.

We found there was a perception that more experienced staff refused to work on the delivery suite and identified more junior midwifery staff would be continually moved to where there was high activity namely delivery suite.

During the pandemic we were informed that some midwives in specialist roles were redeployed to support the general wards by carrying about basic nursing care for example bed baths. However, we did not find any midwives in specialist roles supported staffing concerns on the delivery suite or antenatal and post-natal wards. The senior leadership team were aware of this and informed us this formed part of their ongoing strategy to ensure specialist midwives maintained their skills by undertaking one clinical shift per week or fortnight.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

The trust had now made some improvements to the maternity leadership and governance structures. However, these changes had not yet been fully implemented and there was no confirmed date for this structure to be achieved by. This meant leaders still lacked oversight and assurance in some areas. An external organisation had recently conducted a review of the maternity governance at the trust. We were unable to review the findings as this was awaiting final sign off.

Staff at all levels were not always clear about their roles and accountabilities.

The department had high levels of senior staff in interim positions which meant the leadership team lacked stability. There had been regular senior staff changes which further impacted staff as they were unclear about the leadership teams' roles and functions.

Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The Maternity Transformation Assurance Committee ensured there was oversight of the delivery and evidencing of the first Ockenden Report and Maternity Transformation Plan actions.

However, these process improvements were not always aligned to the internal maternity governance processes and opportunities for improvement in governance processes were sometimes missed.

The trust was conducting a review of the governance team structure and had begun to recruit a dedicated head of clinical governance, initially for a six-month period. The trust has also set up two new divisional governance forums, neonatal and obstetric incident review (NOIR) and division oversight group (DOG) meetings. The aim was to ensure investigations were thorough and completed in a timely way to allow for learning to be shared as quickly as possible to prevent recurrence. However, these meetings and processes were not yet fully embedded and still required further streamlining.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior maternity staff monitored maternity performance through the maternity dashboard, with red, amber and green colour coding. This enabled staff to identify where the department was performing better and where improvement was needed. However, the maternity dashboard was not displayed in clinical areas, this meant that staff and the public were not clearly informed of the outcomes for women and babies.

Maternity leaders mitigated gaps in maternity staffing risks by moving staff to where they were most needed, in line with the escalation policy. Senior maternity staff had a clear understanding of the frequency of staff movement.

The service had a maternity risk register to identify, record and mitigate risks and mitigating actions. There was alignment between the risks recorded on the risk register and what staff were concerned about. The risk register recorded the dates when the risk was last reviewed, the risk owner and the date the risk actions should be implemented by. However, the risk register did not record the date each risk was added to the risk register to enable service leaders to monitor whether risks were mitigated in a timely way.

Senior leaders were not using the dashboard to monitor workforce performance indicators such as sickness, mandatory training compliance and skills and drills training for all grades of staff. This should be monitored on the dashboard to improve compliance and identify areas for improvement.

Information Management

The service did not always collect reliable data and analyse it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

The service had improved its processes to act on recommendations and actions from external reviews of incidents and the performance of the maternity service. However, the service leaders recognised improvement was still needed to ensure these changes were implemented quickly to prevent recurrence.

The birthing rooms in the Wrekin midwifery led unit did not have dedicated computers which meant patient information was duplicated as it had to be manually written by staff and later transferred onto electronic records. Staff may not have fully up-to-date information about the women they were caring for.

The database used to record the maternity specific training compliance rates were not linked to the corporate training database. This meant staff training requirements and due dates were not visible to staff. The maternity education team needed to manually record staffing training compliance and requirements. The trust was addressing this as they were implementing a database which would give staff easy access to their training information and take ownership for ensuring they complete it.

The service was planning to move all records to electronic records with the role out planned to start in August 2021. The service had a lead and superusers to assist staff with this process. The service aimed to improve overall patient care from this implementation as care for women would be more coordinated.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme 2020 and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK Mothers (MBRRACE-UK.) This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

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

The maternity service was supported by several external organisations to help embed improvements the service was required to make in the maternity service in response to the requirements of external reviews of the maternity service. Senior staff were also engaged in Sustainability Transformation partnerships (STPs) relevant to the whole service.

Maternity staff were engaged with the Local Maternity Neonatal System (LMNS). They were working towards a buddy system with neighbouring LMNS. The service had a positive and productive relationship the local MVP who offered support, challenge and co-production to the service. The service in collaboration with the MVP had recently introduced the 'UX' ('User Experience) card system to gather direct, actionable user feedback, and which was praised by the local media and by the British Intrapartum Care Society.

The maternity service worked with the MVP to involve a range of equality groups to inform the planning for the service. The MVP recently held a meeting about increasing the diversity of the MVP and to discuss how to improve engagement with harder to reach women.

A Maternity Services User Group (Maternity Voices Partnership), supported by the Trust's Patient and Public Involvement (PPI) department informed the decision-making process for the Trust's Maternity and Neonatal Services.

The MVP had recently involved in the transformation workstreams and the delivery suite forum. They had also been involved in a discussion regarding website content to tailor communication to needs of women from a Black, Asian and minority ethnic (BAME) background.

The Maternity Voices Partnership in Shropshire and Telford and Wrekin had been working with the Maternity Transformation team at the trust to ensure the women and families voices were being heard and involved in the ongoing transformation work. They had been coordinating the development of a system to collate themes collated by the MVP, such as language and communication and continuity of care. GovernancutesV0.1Page -11·Lateral Flow ·

The postnatal ward allocated a colleague of the day to acknowledge where staff had performed well.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff were still developing an understanding of quality improvement methods and the skills to use them to support sustained improvement of the service. Despite staff being focused on implementing the improvements required to ensure women received safe care and treatment they still promoted innovative practice.

Some previous concerns we had told the service required improvement at our previous inspection remained. For example, not all staff had completed mandatory training, including safeguarding of vulnerable children and adults in line with the trust target.

Maternity

The maternity senior leadership team had made some improvements regarding the governance and oversight of risk and quality improvement, this was not yet fully embedded and still required further improvements.

Improvements had been made to grade incident harm and report incidents correctly. However, the process was not yet streamlined and the current governance processes of incident reviewing delayed initial learning and taking action to prevent recurrence.

The senior leadership team had improved oversight of the relevant risks within the service to identify mitigations; but this was not yet fully embedded.

The service had made several improvements following our previous inspection where we had identified areas for improvement, for example:

- The service now ensured high risk women are reviewed in a suitable environment by the most appropriate staff member.
- Staff now asked women about domestic violence in line with trust policy.
- All areas of maternity now had twice daily ward level huddles to ensure information is shared with all staff.
- The service had now colour coded the maternity clinical dashboard to clearly indicate where compliance levels were below the national or local targets.
- The board at the midwives' station on the postnatal ward no longer had women's names clearly displayed for visitors to see.
- Most staff now had an annual appraisal.
- The service had launched a Maternity Transformation Programme supported by an external agency to monitor and improve the safety and care provided to women and babies in maternity.

Senior leaders were supported by several external organisations in both clinical practice and incident management to provide an additional level of scrutiny. They assisted the service to act on the outcomes and actions from serious investigation reviews, recommendations from the Healthcare Safety Investigation Branch(HSIB) and the first Ockenden review in a timely way. For example, staff were now conducting fresh eyes checks every hour for continuous fetal monitoring in line with Saving Babies' Lives Care Bundle. This was in response to learning from previous incidents where cardiotocography's (CTGs) had been incorrectly categorised and staff were not always regularly conducting CTG monitoring. However, the governance of incident reviewing needed to be further refined as it still took the service too long to ensure actions were taken to prevent recurrence of similar incidents.

The service now had a better understanding A new Saving Babies' Lives midwife was now in post who monitored the service's progress to implement the actions required by the Saving Babies' Lives care programme.

The service had several examples of innovative practice from the last 12 months. For example, the service had launched a postnatal video with the local MVP by engaging with women to provide pregnancy information on a range of topics including signs of a healthy baby and postnatal depression. After giving birth, every new mum was given details to access the postnatal video. The card also provided contact details for the Shropshire and Telford and Wrekin Maternity Voices Partnership who co-produced the card and details of a digital app for parents and parents-to-be.

The service was planning a new pelvic health service for pregnant women and new mums to prevent and treat incontinence and other pelvic floor issues as they were selected to be an early implementer of this service. This is part of

the NHS's Long-Term Plan commitment to improve the prevention, identification and treatment of pelvic floor dysfunction, so that fewer women experience ongoing issues after giving birth and later in life. Clinics will provide specialist multidisciplinary support to women with symptoms, with specialist physiotherapists, a specialist obstetrician and a specialist midwife attending the clinics. Every woman receiving maternity care at the trust will be able to access the service throughout their pregnancy. This includes providing exercises that can help to prevent problems from developing in the first place. Physiotherapists can teach women how to exercise pelvic floor muscles correctly, give advice on diet and fluid intake as well as helping women to monitor their progress.

In line with the Better Births Postnatal Improvement Plan guidance which states women should have the opportunity to re-visit their birth experience, the maternity service supported by the Local Maternity Systems and MVP has developed a birth reflections service to support women's emotional wellbeing. External funding has been secured for some midwives to complete specialist training to run this service. A steering group, for this project is currently meeting regularly.

Medical care (including older people's care)

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however, not everyone had completed it. The service did not always provide staff with time to complete mandatory training.

Nursing staff did not always keep up to date with their mandatory training. A 90% target was set for completion of mandatory training. Up to date training compliance data sent to us following the inspection showed the target was met for three out of 10 mandatory training modules for which registered nurses were eligible. Non-registered nursing staff were compliant with three out of 10 mandatory training modules.

Medical staff did not always keep up to date with their mandatory training. A 90% target was set for completion of mandatory training. Up to date training compliance data sent to us following the inspection showed the target was not met for any of the eight mandatory training modules for which medical staff were eligible.

Mandatory training for new staff was incorporated into the induction, and mandatory training compliance was reviewed as part of annual appraisals.

The mandatory training was comprehensive and met the needs of patients and staff. Training was mostly online during the COVID-19 pandemic, however face to face sessions had restarted.

Staff received training on sepsis recognition and treatment. Training levels had improved to 84% for medical and nursing staff since 2019. Furthermore, 81% of all staff had completed training in the use of the National Early Warning Score (NEWS2).

As of the end of June 2021, an average of 66% of relevant staff had completed blood transfusion training. The service had continued to complete ward based training sessions such as falls prevention of which 91% of ward-based staff had completed at the time of the inspection.

Data provided by the trust showed 73% of nursing and 81% if medical staff had completed basic life support which was below the trust target. The service did not provide us with immediate life support (ILS) training compliance data. However, the service risk register stated there were insufficient numbers of nursing staff in the coronary care unit trained in ILS. As a mitigation, the service planned the rota so there was at least one nurse on shift trained.

Not all clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. On average 64% of nursing and medical staff had completed tier one dementia training and only 34% of allied health professional had completed it. A plan was in place to meet the expected level of compliance by September 2021.

Just over half (54%) of registered nurses had completed training in learning disabilities. Compliance was worse for non-registered nurses (48%) and allied health professionals (36%). The service did not provide us with data for medical staff.

Training compliance was monitored by managers who alerted staff when they needed to update their training. However, staff were not always given the time to complete it. Most staff and managers we spoke with told us staff were expected to complete on-line mandatory training in their own time and were not always given the time back. Some managers told us they did not have enough staff to provide them with dedicated work time to complete training and the service would not allow staff to take the time back.

Safeguarding

Staff had not all completed training appropriate to their role on how to recognise and report abuse. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to apply safeguarding knowledge.

Staff received training specific for their role on how to recognise and report abuse, however, not all staff had completed it. A 90% target was set for completion of level two mandatory safeguarding adults and children training. Up to date training compliance data provided following the inspection showed the target for safeguarding adults and children level two training was not met for registered nurses or medical staff but was for non-trained nursing staff. This was a significant improvement for medical staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. An assessment tool was used to gather information which helped staff identify any issues. Staff were aware of the signs of abuse and told us they would report any concerns to the ward manager or safeguarding lead. There were systems to highlight any safeguarding concerns. We saw safeguarding issues were discussed at handover and daily huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would escalate any concerns to the safeguarding lead, as well as their manager. All wards we visited had a safeguarding process chart with key contacts. During our inspection we saw detailed examples of safeguarding referrals made by staff having identified patients at risk of harm.

Staff knew how to follow safe procedures for children visiting the ward. However, at the time of our inspection, visiting was restricted, and no children could visit due to the COVID-19 pandemic.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff kept equipment and premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from infection.

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records we reviewed during our inspection were up-to-date and demonstrated all areas were cleaned regularly. This included general cleaning, cleaning of patient areas and equipment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was cleaned after use and stickers were used to enable staff to recognise when equipment was last cleaned. Reactive decontamination took place in side-rooms and bathroom areas when a patient with an infectious illness was discharged or moved to another ward or area.

Staff did not always follow infection control principles. Compliance with hand hygiene practice was variable. Staff did not always wash their hands before and after attending to patients' hygiene needs on ward nine, 11 and on the acute medical unit. Furthermore, staff completing patient observations on ward 17 did not wash their hands or use sanitising hand gel between patients. Some staff were observed not to decontaminate their hands before entering a ward as instructed.

Whilst all staff wore face masks, not all staff were clear on the trust's policy on their use. Staff we spoke with told us they were required to change their mask on entering a ward, but this was not outlined in trust policy. This only applied if patients had aerosol generating procedures in a bay, which required masks to be worn on entry to that area and removed on exit. Some staff were observed not to decontaminate their hands before entering a ward as instructed.

However, most staff used personal protective equipment (PPE) such as gloves and aprons and these were available across all areas. Hand sanitiser gel was available on entry to and within all wards and areas. All staff were bare below the elbow. Following the inspection, the service provided us with their infection, prevention and control (IPC) and hand hygiene audits. IPC audits from January to June 2021 showed the service was generally above 90% compliance except for ward 15 which averaged 87%.

COVID-19 precautions were generally safe. Gel sanitiser and masks were freely available. Suitable posters were visible across the hospital and medical wards regarding IPC, COVID-19 and social distancing measures. However, we found staff did not always comply with social distancing precautions when required. For example, we saw staff congregating at nurses' stations and offices for clinical staff on wards.

Clear curtains had been introduced between bed spaces, which were wipe clean. This was to promote social distancing in line with COVID-19 guidance. It also allowed patients and staff to see each other when their privacy curtains were open.

Patients were regularly tested for COVID-19 using polymerase chain reaction (PCR) tests. They were tested on the day of admission, day three and five following admission and weekly thereafter. However, staff were not routinely tested unless they were symptomatic, or they were working in an area where there had been a COVID-19 outbreak. There was a voluntary lateral flow testing process which staff could choose to consent to. Data provided by the trust showed that on average, 18% of frontline staff had participated in the lateral flow tests from April to June 2021.

Infection prevention and control practices in relation to endoscopy were in line with best practice.

Dialysis machine decontamination processes were safe and processes to improve safety had been implemented. However, during our inspection we were made aware of an incident where an isolation machine was used repeatedly for other patients. Following the inspection, the service advised us the machine had been cleaned as per the standard protocol. However, acknowledged isolating the machine is an additional safeguard that was not complied with. The service provided assurance additional measures had been put in place to avoid a reoccurrence. No harm had come to patients.

Medical care (including older people's care)

Hospital acquired infection rates for the medical care core service at Princess Royal Hospital from April 2020 to March 2021 showed there was one case of Methicillin-resistant Staphylococcus Aureus (MRSA), 12 cases of Methicillin-susceptible Staphylococcus Aureus (MSSA) and eight cases of clostridium difficile and four catheter associated urinary tract infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. Storage space was limited on most wards we visited. For example, hoists were stored in patient bathrooms or corridors on most wards we visited. A fire exit on ward 17 was partially restricted due to several items of equipment such as seated scales, a hoist and mobility equipment being stored against the wall. A sign on the wall instructed staff not to store equipment yet equipment continued to be stored there. This presented a risk of accidental trips and a risk to vulnerable patients. Staff told us they had nowhere else to store equipment but would arrange for items to be removed.

We were not assured the access to and space in bay A on ward nine was adequate to enable sufficient access for equipment required in an emergency. There was limited space in the bay and beds were very close together. Managers cited this as a known risk which they had escalated yet was not on the service risk register. Some assurance was provided following our inspection risks were mitigated by only allocating low risk patients to the bay. For example, they would not admit patients requiring enhanced supervision, requiring equipment such as hoists and bariatric equipment or requiring a high low bed. However, we found this not to be the case during our inspection as we observed patients living with dementia were admitted to the bay. This meant mitigations were not fully embedded and patients were exposed t potential harm.

Store cupboards and sluice rooms did not always have a lock on the door to prevent unauthorised access. Patients could access these areas, containing harmful chemicals and equipment, which presented a risk of harm. For example, the sluice rooms on ward 11, 15 and 16 did not have a lock to prevent unauthorised access and contained chemicals such as bleach which we observed were not securely stored in a locked cupboard.

The kitchen on ward nine was in a side room. Managers told us this was temporary whilst the kitchen was being refurbished. The state of the kitchens was added to the service risk register in relation to wards nine, 10, 11, 15, 16 and the acute medical unit. The risk registers described the kitchens as ‘in a state of disrepair, which is a significant health and safety and infection risk’. There was a plan to refurbish all kitchens which was underway at the time of the inspection.

There were some areas within the division which were safe and well designed. Corridors and communal areas were generally wide and spacious to allow passage of beds and wheelchairs. The design of the endoscopy unit was in line with national guidance.

The service did not always have enough suitable equipment to help them to safely care for patients. Wards ten, 11 and the acute medical unit had limited or no stock of male and female urinals on the day of our inspection and three days prior. Feedback from staff suggested this occurred on a regular basis, including limited access to clean linen and patent gowns. Staff on several wards also told us they often struggle to find patient observation machines, which were used to monitor vital signs, as there were not enough on the ward. This presented a risk of patient observations not being reviewed and recorded on time.

Bariatric equipment was available and accessible. Bariatric beds and chairs were used appropriately. Staff were provided with training to use specialist equipment when delivered to the ward, so they knew how to use it safely.

Annual safety tests of electrical equipment were not up to date. We reviewed the most up to date service equipment asset log and found annual safety tests on equipment were not up to date. Of 248 items of equipment logged within the medical service,144 (42%) items of equipment had not been tested within the planned testing date. The longest delay in testing was 322 days after the planned testing date. Equipment items included thermometers, monitors, suction pumps, scales, syringe drivers and infusion pumps. We were not assured there was a robust process for maintaining equipment to ensure it was safe for use.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment for use in an emergency was available in all areas we visited. Staff carried out daily safety checks of resuscitation equipment across all wards we visited. Patient call bells were generally within reach and staff mostly responded quickly when called. Staff were generally within patient bays and were on-hand to assist patients. Staff checked call bells worked.

The service had suitable facilities to meet the needs of patients' families. Each bed space was provided with a bed, chair, patient locker and over bed table. Clear curtains had been erected between patient bays as an additional measure to prevent the spread of COVID-19.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks. Performance in relation to staff identifying and quickly acting upon patients at risk of deterioration had improved but practice was not always safe.

The service used a nationally recognised tool to identify deteriorating patients. Improvements had been made in the timely completion of clinical observations; such as blood pressure, heart rate temperature, oxygen levels and respirations. The National Early Warning Score (NEWS2) was used to record clinical observations and identify patients at risk of deteriorating. All but one of the 22 patient NEWS records we reviewed were consistently recorded in a timely manner. However, two out of three endoscopy records did not record a NEWS score but did monitor observations. Electronic 'Patient Status At a Glance' (PSAG) boards provided a live overview of information about patient risk, NEWS scores and timeliness of them. During our inspection we observed NEWS scores were generally completed within set timescales. The nurse in charge of each ward had a good oversight of patients scoring high on NEWS and could demonstrate the actions they had taken to manage the patient. Audits demonstrated good compliance.

Patients were not always escalated appropriately in line with trust policy. Deteriorating patient stickers were introduced for staff to document set actions to be taken to manage a deteriorating patient. We found these completed in only five of the 11 patient records we reviewed, where escalation was required. However, the records did demonstrate staff acted and the patients had been escalated in a timely manner. Weekly escalation compliance audits from March to June 2021 demonstrated patients were not always escalated in line with trust policy. However, audit outcomes indicate this had improved overtime. The service introduced an effective process to identify non-compliance. For example, weekly ward manager and matron audits were undertaken to assess compliance against the deteriorating patient policy. Furthermore, ward managers were required to follow a daily process of reviewing all records of patients who had scored a NEWS of five and above in the previous 24 hours, to monitor if they had been appropriately escalated in line with trust policy.

Medical care (including older people's care)

Whilst improvements had been made, they were not fully embedded across all wards. Deviations from the deteriorating patient policy in terms of escalation had been identified in previous serious incidents. Whilst we saw monitoring processes were in place and improvements had been made, the outcome of audits continues to demonstrate variable compliance with performance.

Staff did not always complete relevant risk assessments for each patient and risks were not always effectively assessed. Recognised assessments tools were used to assess specific risks such as falls and pressure ulcers. Whilst improvements had been made in some areas; risk assessments were not always updated, and risks related to specific conditions were not always assessed and mitigated. Nursing assessments were not fully completed in 18 out of 22 records we reviewed. Staff did not always document key information to assess a patient's holistic needs and help staff safely care for them.

The risk of a patient developing sepsis was not always effectively assessed by staff. Eight out of 21 sepsis screen assessments we reviewed in the nursing assessment booklet were not accurately completed by nursing staff to indicate whether a patient was low risk or high risk of developing sepsis. In seven of these cases, there was no impact on the care received. However, a patient on ward ten was identified as red flag sepsis and actions to treat them were not all completed within the hour. For example, intravenous fluids (IV) and antibiotics were not administered until one hour 35 minutes after the sepsis clock was started. All other actions were completed in a timely manner and no harm came to the patient.

Diabetic patient needs were not effectively assessed. Diabetes status and capillary blood glucose levels were not accurately recorded in the nursing assessment booklet as required in eight diabetic patient records. Seven out of eight patients did not undergo an assessment of the condition of their feet as required. Documentation did not address specific needs such as how diabetes was controlled or assessment of any diabetic related conditions. Generic diabetes care plans were available but only in place for two out of eight diabetic patients. This meant there were not any personalised plans in place to determine the patient's dietary requirements, blood glucose monitoring and guidance for administration of medicines and management of the patient in the event of deterioration.

We continued to see poor compliance with completion of bed rails risk assessments. Nine out of 16 bed rail assessments were not fully assessed or completed. For example, staff had not completed the bed rails matrix to assess mobility level and state of confusion to determine whether bedrails were indicated. Where bed rails had been ticked as safe to use, the rationale for this decision was not always documented. Reviews were generally completed, however there was no rationale as to why bed rails were used or not. Bed rails were used when contraindicated and unsafe to be used for five patients we observed. This meant patients continued to be placed at risk of serious harm from bedrails.

Improvements were noted in the completion of falls risk assessments. However, risks were not always fully assessed, reviewed and specific to individual needs of the patient. All 22 records we reviewed had a falls risk assessment completed upon admission. However, five had not been reviewed in line with trust policy. Lying or standing blood pressure was not documented in 19 out of 22 records. Three out of 19 patients identified at risk of falling did not have a completed falls prevention management plan. A further seven patients prevention plans were not fully completed and did not reflect the risks identified.

Limited assurance could be provided to demonstrate the improvements effectively identified and mitigated against patients with changing needs. For example, a patient's risk had not been reviewed following an unwitnessed fall on ward seven. Multiple falls in hospital was a theme in three serious incidents we reviewed. On ward 17 the level of risk for a patient had changed significantly from the point of admission yet the risk assessment did not reflect the heightened

risk of falling. Serious incidents we reviewed from June 2020 to May 2021 identified three incidents whether the patients had fallen in hospital prior to the fall meeting the serious incident threshold. This meant patients continued to be exposed to harm from falling as risks were not always being reviewed following a fall to ensure individualised action was taken.

Documentation did not enable holistic assessment of individualised needs to support effective falls prevention planning. Staff indicated a risk was present with a tick against a pre-set measure. The rationale for identifying the risk was not documented in any of the records we reviewed which prevented staff from understanding the patients' individual needs.

Staff were not always aware of or dealt with specific risks to patients. Improvements in staff awareness of risks associated with falling had been made. However, improvements were not consistently embedded. Oversight of patients at risk of falling had improved. Staff implemented measures to reduce the risk of falling such as falls wrist bands, anti-slip footwear, clutter free environments, low beds and crash mats. Records we reviewed generally reflected what actions had been taken.

Processes to observe patients at risk of falling requiring closer supervision were not always consistently implemented. It was not always clear who was responsible for tagging a bay where more than one patient was admitted who required closer observation. A tagging system was not in place in bay B on ward 11 where there was more than one patient at risk of falling. We observed one patient who was confused and unsteady attempting to get up and leave the bay. We had to intervene and alert staff to the risk. Staff told us they were short staffed and had to support other bays, however, there were no mitigations in place. Unwitnessed falls was a theme in previous serious incidents we reviewed. This meant patients were not always effectively supervised in line with trust policy to reduce the risk of unwitnessed falls.

Staff sometimes lacked situational awareness in their approach to falls prevention. For example, we identified a patient at high risk of falling on ward 17 placed in a side room furthest away from the nurses' station. Staff implemented standard falls prevention methods but did not consider how they would mitigate the risk of being so far away and out of sight of nursing staff. Furthermore, patient walking aids were sometimes out of reach which meant if a patient got up to walk, they were at increased risk of falling.

Fluid balance monitoring was inconsistently recorded for patients on a fluid restriction and those at risk of dehydration. Out of 22 records we reviewed, 15 fluid balance charts were not fully or consistently completed. This included a patient with chronic kidney disease who required strict monitoring.

There was inconsistent practice around pressure ulcer prevention and management to reduce the risk of hospital acquired (HA) pressure ulcers. Waterlow risk assessments were used to assess a patient's risk of developing a pressure ulcer and these were generally completed on admission and reviewed in line with trust policy. However, the on-going assessment and monitoring of patients at risk of developing a pressure ulcer or those who had an existing wound was poor. Nine out of 14 skin assessment pressure ulcer prevention booklets we reviewed were not been fully completed. Pressure ulcer prevention assessments were not always completed or reviewed. Body maps were not completed accurately so did not effectively record the condition of the skin. Where wounds were present, documentation lacked detail as to the size and depth of the wound. This meant that a nurse could not assess if a patient's skin was improving or deteriorating. Repositioning frequency was generally not documented. Documentation of repositioning was inconsistent in all nine records we reviewed. Nine patients required a pressure relieving mattress, however four did not have one in place. This meant patients continued to be at risk of suffering a preventable deterioration in their skin.

Bariatric equipment was not always in place for patients who needed it. For example, we identified two patients on ward 11 who did not have a bariatric bed. In one record it was documented the patient did not initially want one and in the other the assessment was not fully completed.

The individual needs of patients displaying challenging or aggressive behaviour were not always clear or documented. Enhanced supervision risk assessments were not always fully completed or did not contain enough detail to assess patient needs. Two out of eight patient records, where the patient displayed challenging behaviour, did not have a risk assessment completed. This meant two patients did not have their individual needs identified or met to support staff to safely and effectively care for the patient. Of the six that were completed, there was limited information to guide staff how to effectively care for the patient. For example, assessments lacked detail of the patient's behaviour causing concern, their current state and individualised strategies to support the patient.

Enhanced observation charts were mostly in place where required as part of the bedside records. However, we found they were not always up to date and did not outline what actions were taken to alleviate distress or reduce any risks identified in the assessment. The trust policy asks staff to document 'What did we do to alleviate any distress, & how did the person respond / Have we met needs re Pain, Hunger, Thirst, Elimination, reduce Noise'. The records mostly commented briefly on the patient's behaviour. There was variable compliance with hourly updates being documented by staff.

Practice in relation to the assessment of venous thromboembolisms (VTE) was inconsistent. We found VTE assessments were completed for all patients upon admission and recorded on the electronic patient record. However, evidence patients had undergone a VTE review within 24 hours of the initial review or when there was a change in condition was limited. For example, one patient had undergone a surgical procedure to insert a central line and we did not see evidence of a VTE re-assessment post-surgery. Four patients were assessed as high risk of developing a VTE yet there was no evidence of a re-assessment. We observed one patient being re-assessed during a ward round but did not see this recorded on the electronic system.

The service did not always effectively assess and plan for the risks associated with pre-existing conditions patients were admitted with. For example, a patient with a stoma did not have a care plan to assist staff in caring for them. Staff caring for the patient at the time were competent to manage the stoma. However, an absence of a care plan meant there was a risk of poor care should temporary or more junior staff with limited experience be caring for the patient. Staff looking after the patient had not received training in this area. We also identified a patient on Continuous Positive Airway Pressure (CPAP) for obstructive sleep apnoea who did not have a care plan. Whilst the service had a standard operating procedure in place, there was no specific care plan to ensure staff were aware how to support the patient safely should they no longer be able to self-manage the CPAP or if their oxygen levels deteriorated. Staff looking after this patient has not had any specific training to care for a patient on CPAP at the time of the inspection. Processes were in place to safely care for patients requiring non-invasive ventilation (NIV).

Access to specialist stroke assessment and treatment was variable. A below average number of patients received timely medicine within the hour to prevent the stroke worsening. However, the service had improved and was performing consistently with the national average in the proportion of eligible patients being given thrombolysis following admission. Staffing levels had improved since the last inspection and supernumerary staff were available to respond to stroke patients admitted to ED and directly to the ward. More registrar grade medical staff had been trained to administer thrombolysis. However, a continued risk cited by staff and on the service risk register was the lack of capacity to complete Computerised Tomography (CT) scans within the hour impacted time to receive appropriate medicine.

Medical care (including older people's care)

Not all patients were reviewed by a consultant within 14 hours of arrival to hospital. From April 2019 to March 2020, 65% of patients had been reviewed by a consultant within 14 hours of arrival. More up to date information was not provided. Consultant review times were not always recorded in patient records therefore we could not determine compliance during our inspection. Each morning the consultant who was on call the night before, with the on-call juniors, reviewed every new patient who had been transferred out from the acute medical unit overnight, who had only been seen by a registrar. Consultant board rounds were held daily on each ward. Two consultant board rounds per day were held within the acute stroke unit.

The service had 24-hour access to mental health liaison or specialist mental health support (if staff were concerned about a patient's mental health). Furthermore, the service recruited a mental health lead who provided additional support to staff in caring for patients with mental health needs.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw evidence in patients records that patients had undergone assessments with the mental health liaison team.

Key information to keep patients safe when handing over their care to others was inconsistently communicated. A transfer of care form was included in the nursing assessment booklet to communicate key information when transferring from one ward to another. These were completed in only eight out of 22 records where a transfer had taken place. This meant there was a risk key information relating to managing a patients' specific needs were not always clearly handed over. There was evidence within recent serious incident reports that a lack of formal handover of falls prevention methods were contributory factors in the patient falling.

Shift changes and handovers included all necessary key information to keep patients safe. For example, they included a brief overview of all patients, risks such as falls, capacity status, actions required and treatment plan.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers did attempt to mitigate this by regularly reviewing and adjusting staffing levels and skill mix. Bank and agency staff were given a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Leaders, managers and staff described staffing as being the main risk to service care and provision. This was included on the service risk register. The number of nurses and healthcare assistants did not always match the planned numbers. Planned and actual staffing numbers displayed at the time of our inspection showed staffing levels did not always meet planned staffing levels. Managers escalated where staffing levels were reduced but they did not always receive additional staff. Data received from the trust following our inspection showed that from June 2020 to May 2021 0.2% of registered nurse shifts and 0.5% of health care assistant shifts were not filled. We reviewed the roster for period 11 July 2021 to 7 August 2021 which showed a significant number of shifts were not filled.

The service had high and variable vacancy rates. From July 2020 to June 2021 the average vacancy rate for registered nurses and health care assistants was higher than the trust 11% vacancy target. Whilst the vacancy rates had generally improved, managers and staff felt the pressure of long-term high vacancy rates. For example, not being able to complete patient risk assessments in a timely manner. The service had undergone an international recruitment campaign and had plans underway to further fill vacancies.

Medical care (including older people's care)

The service had a high volume of junior staff. This was a challenge for managers when planning the roster to ensure appropriate skill mix. Junior nurses recruited from abroad required additional support to adjust to working in a new country and environment. Lack of support for junior nurses was escalated and addressed and support was put in place, but ward managers expressed they often lacked confidence to take on nurse in charge roles or shift co-ordination roles. This was on the service risk register.

The service had high turnover rates. From June 2020 to May 2021 the average annual turnover rate for registered was 17% and health care assistants 14.8%. Both were higher than the trust turnover target of 11%.

The service had high sickness rates. From June 2020 to May 2021 the average sickness rate for registered nurses and healthcare assistants was higher than the trust sickness target of 4%.

Managers and staff told us they did not always receive additional staff to provide one to one enhanced care when escalated but this was improving. For example, we observed Ward 15 did not have additional healthcare assistants to provide one to one enhanced care to more than one patient who required it. However, mitigated through supernumerary staff and the patients were always monitored.

Agency staff were used to fill gaps and managers worked clinically when required. Staffing levels were discussed at ward handover meetings. Staff discussed acuity of patients, activity on the ward and when additional support was required. Processes were in place to escalate staffing issues to the matron who escalated the gaps at daily safety meetings.

Staff reported incidents where staffing levels were affected. From June 2020 to May 2021, 98 staffing incidents had been reported by staff. In June 2020 there were three red flag staff incidents reported on wards nine, 10 and 11 where patient safety had been compromised as a result of staffing levels. All were night shifts where there were not enough registered nurses as a result of unexpected absence.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, this was not always done in a timely manner. Ward rotas were devised using the safe care nursing tool. Issues identified with staffing vacancies and fill rates were escalated to matrons. Managers had access to a staffing plan which showed agreed staffing levels and actual staffing levels. Managers used this to identify any gaps and request bank or agency.

Matrons reviewed staffing levels twice yearly which was submitted to the director of nursing. Matrons told us rosters were approved at least 6-8 weeks in advance to make sure the skill mix was right. However, several staff we spoke to told us rosters were not always approved within reasonable timescales. We reviewed matron and ward manager medicine division meeting minutes. Matron and ward manager meeting minutes on 30 June 2021 indicated the Royal College of Nursing (RCN) had received concerns rosters were not being sent out in a timely manner and requested a meeting with the trust. Freedom to speak up guardians also raised concerns rosters were not being authorised which impacted on patient safety as skill mix was not always confirmed to enable appropriate bank and agency cover.

Concerns were identified about the night-time staffing levels on ward ten, care of the elderly ward. Some staff felt staffing levels and skill mix left the ward unsafe. The registered nurse to patient ratio was approximately 1:9 with three healthcare assistants to support. The ward often had patients requiring enhanced supervision and staff told us there were a high ratio of junior nurses who were not ready to be in charge of the ward. However, on occasions they were in charge alongside agency staff. Staff told us this had been escalated as a concern and a recommendation provided to

increase the registered nurse numbers at night-time, but it had not been responded to. We reviewed the risk registers for care of the elderly and saw 'high number of nursing vacancies and junior staff in post' as a risk with the effect being 'the nursing team struggle to give safe, effective care to patients'. The risk did not specify the night-time nurse levels or how they were mitigated, therefore we were not assured this had been effectively addressed.

The ward manager could adjust staffing levels daily according to the needs of patients. A matron of the day was responsible for completing a safe staffing overview. Managers reported into the matron daily on staffing levels, skill mix and acuity. This included any requirements for enhanced care which was presented at daily safety briefings.

The service had high rates of bank and agency nurses used on the wards. High levels of bank and agency staff were observed during our inspection. Data from June 2020 to May 2021 showed 34.7% of registered nurse shifts and 31.5% of health care assistant shifts were covered by non-substantive staff.

Managers could not always limit their use of bank and agency staff, however, where possible requested staff familiar with the service. Managers we spoke to raised concerns that the high percentage of agency staff usage significantly impacted on the service ability to implement quality improvements and lessons learnt following incidents.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff received an orientation to the ward including an overview of current topics, risks and emergency procedures. Managers kept a log of agency induction checklists on the ward.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. Locum Doctors used did not always have a full induction.

The service did not always have enough medical staff to keep patients safe. Nursing staff told us doctor shortages impacted as they were not always able to respond in a timely manner especially out of hours. Junior doctors told us the impact of this was being unable to respond to requests to review patients, complete daily tasks and discharge patients in a timely manner. Furthermore, junior doctors told us shortages in all grades impacted on them being involved with regular teaching sessions. Senior leaders told us they mitigated junior doctors' shortages by moving doctors to wards where they were particularly short. However, junior doctors told us this was a risk as they were often used to complete tasks such as discharging patients, they had limited knowledge about.

Managers had recruitment plans in place for key vacant post such as stroke consultants and care of the elderly. Service leaders told us the consultants' budget in the medicine division was not fit for purpose, however a recent establishment review had been completed, and business case put forward and approved to increase to 20 whole time equivalent consultants across both Princess Royal Hospital and Royal Shrewsbury Hospital sites. Leaders recognised they still had some work to do to improve recruitment and retention.

During our inspection, medical staff told us there was a shortage of junior doctors. Following our inspection, we requested vacancy rates for medical staff. Data provided for May 2021 demonstrated there were 18.31 whole time equivalent vacancies for junior doctors within the medical division. Six of which were in the nephrology specialty and 3.42 in general medicine. This was consistent with feedback given to freedom to speak up guardians as outlined in information we received following the inspection. Lack of out of hours medical cover and consultant review was cited as a concern from staff.

Medical care (including older people's care)

Processes were in place to review medical staffing. Medical staffing was discussed every Monday with operational managers and the medical staffing department. Medical staffing was planned for the week ahead. The junior doctor rota was planned a week in advance so that gaps could be identified, and cover arranged. The Divisional medical director told us the service works on two junior doctors for every 20 beds and this was mainly achieved. Some specialities had smaller bed numbers but there was still a requirement for two junior doctors. Junior doctors' meetings were held every Friday to review the staffing levels for the weekend.

The service junior doctor co-ordinator role had recently become vacant which meant the junior doctor rota was being jointly overseen by operational managers who were prioritising maintaining the fill rates.

The service had high but reducing vacancy rates for medical staff. From June 2020 to May 2021, the hospital reported vacancy rates for consultants was 13.1% and middle grades doctors 23.1%. Vacancy rates impacted the time to first consultant review, additional pressures to cover the services and support provided to junior doctors. At the time of our inspection only three out of five stroke consultants were available which posed additional pressure to provide cover for the wards and clinics. However, vacant posts were being recruited into. The care of the elderly speciality had a vacant consultant post which was mitigated with associate specialist doctors and registrars covering the ward. Locum doctors were block booked but not all were specialists in care of the elderly and were unable to supervise more junior substantive staff. The service had been actively recruiting and had a consultant planned to start in August 2021. A general medical consultant was available on-call 24 hours a day, seven days per week. There was consultant presence on site from 8am to 5pm. Medical staffing vacancies was on the service risk register and locums were used to fill vacancies whilst recruitment took place.

The service had lower than average turnover rates for medical staff. From June 2020 to May 2021 the average annual turnover was 7.9%.

Sickness rates for medical staff lower than the trust target. From June 2020 to May 2021 the average annual sickness rate was 1.8%.

The service had high rates of bank and locum staff. From April 2021 to June 2021, the service had 25% unfilled medical staff shifts. Managers could access locums when they needed additional medical staff. Locums were recruited to fill vacancies and block booked them where possible. Locum doctors were also used to fill short term sickness.

Managers did not make sure locums had a full induction to the service before they started work. Locum doctors we spoke to told us they did not have an induction. They generally reported feeling not part of the team and pressure to work 'excessive hours'. Locums did not have full access to trust electronic systems such as the email system and did not receive a name badge. This meant that locum doctors were not always included in any safety alerts or invited to governance meetings where learning was shared. Locum doctors told us they did not always receive feedback about incidents, receive memos or any circulations and meeting invites. We discussed this with senior leaders who felt there was a supportive attitude towards locums, however, recognised improvements were required to improve their integration and access to governance processes.

The service did not have a good skill mix of medical staff on each shift and reviewed this regularly. In July 2021, the proportion of consultant staff reported to be working in medical care at the trust was 34% which was lower than the England average. The proportion of middle grade was 29% which was much higher than the England average. The proportion of junior (foundation year 1-2) staff was 16% which was lower than the England average. The proportions of registrar staff reported to be working at the trust was 21% and higher than the England average.

Medical care (including older people's care)

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear and up to date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last two inspections. Records were not always stored securely and were not always easily available to all staff providing care.

Patient notes were not always comprehensive. We reviewed 22 nursing and medical assessment records and found 18 were not fully completed and missing key information. Information needed to guide staff how to provide safe and consistent care was not always available. For example, none of the generic care plans we reviewed highlighted the care and treatment each of the 22 patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs.

Records were not always accessible to all staff. Medical staff including locum doctors did not receive timely access to electronic patient records upon commencement of their employment in the service. Locum doctors told us they did not have access to trust communication systems such as email. Following the inspection, the trust reviewed the process and acknowledged there were delays in access being given to doctors, however, we were not assured there was a plan to address this.

Access to computers caused delays in doctors accessing patient records. During our inspection we saw medical staff waiting for computers to become available. Staff told us the impact of this was delays in discharging patients, difficulties tracking patients and the potential to not have immediate access for clinical decision making.

Records were not always stored securely. Medical and nursing records were generally stored in locked trolley. We checked records trollies on most wards we visited and found they were generally locked to prevent unauthorised access. However, we did see on occasion, medical records left at nurses' stations and in offices which were accessible.

Patient bedside records were not always stored securely. For example, on ward 17, we observed bedside records were on clipboards and hanging on the wall outside of the bays. This meant that the patient records were easily accessible to unauthorised persons.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were transferred with patients and access to electronic records were readily available.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The pharmacy team ensured there was a patient centred approach to medicine optimisation. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

There was no system for recording the site of application or removal of transdermal medicine patches. This is important to check that the patch is still in place or to prevent the application of other patches in error. Also, to communicate information about patches when a person is transferred between wards or other healthcare settings. We were informed a process had been developed and was waiting for approval.

Medical care (including older people's care)

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Members of the pharmacy team regularly reviewed patients' medicines throughout their admission and prior to discharge. This involved counselling and discussions with patients wherever possible.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored safely and securely. FP10 prescriptions were stored securely with a robust checking system to track their use. Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Medicine optimisation was undertaken by members of the pharmacy team. Any discrepancies were immediately identified and highlighted to the relevant team. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The antimicrobial stewardship pharmacist undertook reviews and snap-shot audits which highlighted any areas for improvement.

Dedicated sepsis trollies or boxes were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Venous thromboembolism (VTE) protocols were in place. Checks to ensure any necessary prescribing for the prevention of a VTE were undertaken by pharmacists.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not observe excessive and inappropriate use of medicines. The service had improved systems and processes in place to identify patients who were prescribed rapid tranquilisation medication. We saw examples of less restrictive methods being used to manage patients who were being aggressive or were agitated such as one to one assistance and oral medicines.

Incidents

The service managed patient safety incidents well when reported. Staff recognised but did not always report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team but not always the wider service. However, this learning was not always embedded. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. However, staff did not always raise concerns or report incidents and near misses in line with trust policy. For example, staff told us they did not always report falls incidents where no harm had occurred or failures to accurately record fluid balances which impacted on clinical decision making. We also reviewed a patient record on ward 11 where nursing entries indicated aggressive behaviour to staff and the patient had been administered oral sedation. This was not reported as an incident at the time, however, we escalated this to managers and the incident was reported nine days later with identified learning. This meant opportunities for learning and improvements were always made as not all incidents were reported by staff.

Managers shared learning about never events with their staff and across the trust. The service had two never events in endoscopy. All staff in endoscopy knew about them and could describe how learning had been implemented. Both never events had been discussed with staff at different forums such as safety huddles, patient safety groups and staff meetings.

Staff reported serious incidents clearly and in line with trust policy. The service reported 11 serious incidents (SIs) in medical care at Princess Royal Hospital which met the reporting criteria set by NHS England From July 2020 to June 2021.

Managers shared learning with their staff about serious incidents and never events that happened elsewhere. Learning was shared at clinical and operational governance meetings. We observed incidents were discussed and learning identified with actions to disseminate learning.

Staff could describe recent serious incidents on their ward and elsewhere. For example, staff told us about recent pressure ulcer incidents and failures to escalate deteriorating patients. Staff could tell us what their role was in reducing further occurrences of incidents. Staff in the dialysis unit demonstrated to us how they had implemented learning from a recent serious incident.

Staff on ward 17 were able to describe incidents relating to non-invasive ventilation (NIV) therapy on another site where the NIV disconnected from the oxygen supply. Staff could describe steps they took to complete regular checks of NIV connections and how they documented it. There were no patients in on NIV at the time of our inspection, so we were unable to check the learning had been implemented fully, however we were assured staff understood their role and the risks of not checking.

Most staff we spoke to understood duty of candour. We saw the service was open and transparent and gave patients and families a full explanation if things went wrong. Having reviewed serious incident reports, duty of candour had been applied in line with trust policy. Duty of candour was applied to other incidents not meeting the serious incident criteria where there was a near miss and potential exposure to harm.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Some staff told us when they reported an incident, they did not receive feedback from their manager to let them know the outcome. Locum doctors told us they did not receive feedback following incidents. However, we saw evidence that learning from incidents was disseminated at meetings and safety huddles. We spoke to nursing and therapy staff who told us they would be updated about relevant incidents at their morning huddles. We saw that outcomes of serious incident reports were communicated across the trust in weekly newsletter and bulletin emails. However, temporary medical and nursing staff did not have access to electronic communication systems which meant they did not receive this feedback.

Staff met to discuss the feedback and look at improvements to patient care. There were processes in place for staff to discuss incidents and improvements required. For example, weekly ward manager and matrons' meetings took place and learning from incidents was shared across the division and hospital site. Ward based safety huddles took place where learning from incidents was shared.

Changes made as a result of learning and feedback from incidents were not always effectively implemented. Systems to monitor implementation of learning from incidents were not always effective in ensuring improvements had been made and sustained. Action plans to improve the quality of care were not always effective or fully implemented.

Prior to our inspection we reviewed serious incident investigation reports relating to hospital acquired pressure ulcers. We found there were recurrent themes and contributory factors such as body maps and repositioning not being consistently recorded, poor completion of risk assessments, care plans and patient monitoring. Records we reviewed during our inspection provided limited assurance improvements had been made. Managers made us aware of a recent incident where a patient developed a 'grade four' hospital acquired pressure ulcer on ward 11. Skin assessments had not been completed correctly and the patient did not have the correct pressure relieving mattress. Two records on ward 11 demonstrated learning had not been implemented following this incident. Neither had a pressure ulcer prevention plan despite being assessed as high risk of developing a pressure ulcer, one did not have a pressure relieving mattress and one did not have consistent skin surveillance. This meant learning had not been effectively implemented and patients continued to be at risk of harm from developing a preventable pressure ulcer.

We reviewed two serious incidents relating to patient falls and found learning from these incidents had not been consistently implemented. For example, there was learning around implementation of falls prevention strategies, management of patients at risk of falling in a side room and ensuring the tagging system was in place where required. We found these risk factors continued to be an issue.

Speciality learning across sites was not always effectively implemented. We were advised of a near miss in the dialysis unit regarding a breakdown in infection prevention and control procedures for isolating dialysis machines. Following the inspection, we were advised of a similar incident that had occurred at Royal Shrewsbury Hospital in May 2021 where learning had been identified. This learning was not effectively shared across sites in which could have prevented the second incident at Princes Royal Hospital dialysis unit.

Managers investigated incidents thoroughly although there were delays in incidents being concluded. Whilst improvements had been made, not all incidents were reviewed in a timely manner. This meant learning from these incidents could not be identified, shared and implemented in timely manner.

Managers debriefed and supported staff after any serious incident. However, some staff told us managers did not always provide support following aggressive behaviour from patients. Serious incident investigations documented support being offered to staff following an incident. Most staff reported feeling supported by their manager. However, some staff told us when they had experienced aggressive and violent behaviour from patients, such as physical aggression, they were not debriefed of supported by management.

Safety Thermometer

Staff collected safety information and shared with staff, patients and visitors. The service used monitoring results to improve safety.

Safety performance data was displayed on most but not all wards we visited for staff and patients to see. Quality boards were in place on most wards and displayed metrics which reflected ward-based quality and performance audit

outcomes. Performance metrics were updated monthly and at the point of inspection publicised May 2021 data. The service used audit outcomes to determine safety performance. We saw wards had educational campaign boards in place which reflected areas where the ward was underperforming. For example, we saw fluid monitoring awareness boards and falls boards.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance, however, it was not always followed. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A policy was in place to ensure best practice guidelines were worked to. The policy outlined how new guidelines published by the National Institute for Health and Care Excellence (NICE) were logged upon are database with a lead clinician identified. Baseline assessment tools were then used to update and implement new guidance when needed.

For example, since our last focused inspection the trust had updated policies and procedures, we identified as not reflecting most up to date guidance. The trust procedure for the 'Prevention and Management Inpatient Falls guidance was approved in April 2021 by the quality and safety operational group and referenced the most up to date National Institute of Clinical Excellence (NICE) falls guidance for older people 2013. The guidance recommends all patients aged 65 and over received a multifactorial falls assessment and intervention plan.

Furthermore, the trust's, 'Pressure Ulcer Prevention and Management Policy' which was approved in June 2021 referenced the most up to date NICE guidance for pressure ulcer prevention and management 2019 NICE update. This had been updated since our last focused inspection.

Whilst policies were in place, we found they were not always followed by staff. For example, we found patients who were diabetic did not have a diabetic care plan in place. We found staff did not always implement the pressure ulcer prevention and management policy as we saw patients' high risk of developing pressure ulcers did not always have the correct equipment in place as outlined in policy or regular repositioning where required.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not identify any patients who were detained under the Mental Health Act but when asked staff were able to tell us what they would do or who to contact for advice and support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We also observed a board round where patients mental health, well-being and safeguarding needs were discussed.

Managers and staff carried out a programme of repeated audits to check improvement over time. An audit programme outlining participation in national, NICE, specialist and local priority audits was in place. Named data collection or co-ordinators were in place for each audit and the status of the audit was identified. Managers used information from the audits to improve care and treatment, however, during our inspection, we identified areas of non-compliance with policies and procedures therefore we were not assured the audits were always effective in during improvements. For example, nursing standards audits did not always drive improvements in fluid balance monitoring and pressure care management. We found these were continued areas of concern identified at our last inspection, in service audits and poor compliance we found on this inspection.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health, however this was not always documented when required. Specialist feeding and hydration techniques were used when necessary. However, patients admitted with a stroke did not always have timely swallow screening and assessment. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. A range of foods were available to patients to suit their medical and cultural meals. For example, there were options for patients with low sodium and diabetic diets. Staff told us there were soft options available at each mealtime. There were icons on boards above beds indicating if the patient had any special nutritional requirements. Protected mealtimes were in place on all wards we visited.

Staff supported patients at mealtimes when required. Red place mats were used where a patient required assistance, so staff knew who required assistance. These were in place during our inspection, however an audit from 01 April to 31 April identified only 25 out of 34 patients living with dementia had these in place.

Systems were in place to ensure patients at risk of aspiration due to swallowing difficulties had their nutrition and hydration needs met. However, staffing pressures meant stroke patients requiring specialist swallow screens did not always receive this within four hours of admission. Performance was significantly below the national average for stroke patients. At the time of the inspection training had been facilitated to increase the number of staffed trained to complete the swallow screens and another planned for October 2021. Furthermore only 68.4% of patients received a formal swallow assessment by a speech and language team within 72 hours. This was below the 75% target and 89% national average. The service provided assurance patients nutrition and hydration needs were met. All stroke patients received a sip test within the hour to assess whether they were safe to take oral fluids. Patients were provided with intravenous fluids if required. Patients were reviewed twice daily by a consultant where risks were escalated, and nasogastric feeds were prescribed if required. A business case had been approved to recruit additional nursing staff to improve timeliness of swallow screens being completed. In addition, the service had increased the provision of speech and language therapists to provide six-day cover to enable improvements in swallow assessments being completed. This was beginning to improve the wait time for assessment. Whilst there were delays with swallow assessments, we did not see any evidence of harm and there had been no incidents reported at the time of the inspection.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Nutrition charts were in place, however, we found they were not always up to date and there were gaps in most records we reviewed. Nursing quality metrics from March 2021 to May 2021 showed overall compliance with nutrition monitoring was 79% and fluid balance monitoring 72%. Following the inspection, we reviewed a dementia indicator audit completed from 01 April 2021 to 31 April 2021 which showed 18 out 34 patients living with dementia did not have their nutrition and fluid intake recorded accurately. This meant nutrition and hydration monitoring was not effectively implemented for vulnerable patients and those where clinically indicated.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. These were generally completed on admission and then repeated upon transfer to a new ward or within timescales outlined in the trust policy. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, they did not always support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool, however, specialist pain assessments for patients with communication difficulties were not consistently used. Pain scores were assessed and recorded regularly on the electronic patient record. Staff asked whether patients were in any pain during comfort rounds. The abbey pain scoring system as a method for identifying the signs of pain in people living with dementia was used. We reviewed two patient records of patients who were unable to effectively communicate their needs. One record did not have any Abbey pain scores recorded and one patient had one Abbey pain score recorded. Both patients had been assessed by the dementia service who requested the Abbey pain score was used, however this was not acted on. Not all staff we spoke to knew what the Abbey pain score was or where it was recorded. This meant patients who were unable to communicate did not always have their pain effectively assessed or managed.

Patients received pain relief soon after requesting it. Patients we spoke to told us they were given pain relief on request and were comfortable. Staff prescribed, administered and recorded pain relief accurately. Medicine charts we reviewed confirmed pain relief was prescribed and delivered appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. For example, the Sentinel Stroke National Audit Programme (SSNAP), national audit of dementia, national audit of inpatient falls, diabetes, chronic obstructive pulmonary disease (COPD) and lung cancer audits.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards.

Princess Royal Hospital participated in the Sentinel Stroke National Audit Programme Clinical Audit 2020/21. Hospitals performance is graded on a scale of A-E, where A is best, and E is worst. The service was graded C overall from April 2020 to March 2021, demonstrating improvement overall since the previous year which was graded D.

Managers and staff did not always use the results to improve patient outcomes where indicated. Risks associated with poor outcomes for stroke were added to the speciality risk register. For example, risks associated with medical and nurse staffing, therapy staffing, scanning pathways and psychological interventions. We reviewed the stroke improvement programme action plan and saw there were 26 actions, 22 of which had been on the action plan for more than two years, three more than one year and one added in 2021. For example, direct access to computerised

tomography (CT) scanning had been on the plan since January 2019 with an original due date of 30 June 2019. However, this continued to be an area of underperformance. We saw actions from the improvement plan were discussed however, we were not assured there was effective oversight to move the actions forward with most actions continuing to be outstanding.

The trust was below national performance in some aspects of care for patients with lung cancer. To address this the trust had increased the lung cancer nurse specialist team in order to improve patient accessibility to specialists. The service had also implemented a direct to Computerised Tomography (CT) pathway. Monthly lung cancer multidisciplinary meetings were in place and we saw these were well attended.

The service had a dementia workplan in place dated June 2020 to improve outcomes for patients living with dementia. We saw there were actions in relation to assessment and care planning, the environment and governance. Not all actions had been effectively implemented such as addressing night ward moves. A night moves audit had been planned for May 2021 and was now planned for September 2021. The environment was not always dementia friendly. For example, we did not see orientation clocks were visible for all patients and in good working order. Improvements had been made in relation to the care of patients living with dementia. For example, we saw the butterfly scheme was visible and significant improvements were noted in mental capacity assessments, best interests' documentation and Deprivation of Liberty Safeguard (DoLS) applications. However, we continued to find variable compliance with personalised care planning and implementation of 'this is me' documents which were not always displayed at the bedside.

Managers did not always share and make sure staff understood information from national audits. We reviewed divisional governance meetings minutes but did not see evidence outcomes from national audits were routinely discussed or considered in relation to improving the quality and improving outcomes of the service. Divisional governance and management meetings took place and we saw specialities provided feedback; however, this was not in relation to national reporting.

The service had a mostly lower than expected risk of readmission for elective and non-elective care than the England average. In all but one of the specialities the rate of readmission was at or below the England average. From February 2020 to January 2021 the rate of readmission for elective respiratory medicine at Princess Royal Hospital was higher than expected. The endoscopy service was accredited by Joint Advisory Group (JAG). The latest submission to JAG had resulted in the service being fully accredited having successfully implemented an action plan to improve.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified and had the right skills and knowledge to meet the needs of patients. However, junior nurses did not always have the experience to confidently undertake aspects of their role. Staff had the right qualifications, skills and experience to do their jobs, and were supported to develop specialist skills where required. There were trust competencies for nursing skills such as cannulation, which newly qualified staff were supported to complete through competency-based training. The service had specialist nurses providing nurse-led care. Many general nurses completed additional training to support the effective care of patients in the specialism in which they worked.

Junior nurses were sometimes assigned nurse in charge responsibilities due to staffing levels in which they did not always feel confident. This was mostly on night shifts.

Medical care (including older people's care)

Medical staff we spoke with told us junior doctors had implemented their own teaching programme in the absence of a divisional one. Doctors told us this had developed and was now supported by consultants who were generally supportive, and their educational needs were being met. Leaders told us half day teaching sessions were added to doctor rotas on a Tuesday and Wednesday. Half day teachings were included on the rota to ensure teaching time was protected. Junior doctors told us they did not always receive unimpeded access to a consultant and during the COVID-19 pandemic, ward round based learning opportunities had reduced.

Managers gave all new staff a full induction tailored to their role before they started work. Most nursing staff we spoke to told us they received an induction before starting their role. This included a formal induction where they completed mandatory training and a ward based supernumerary period. Overseas nurses who were completing competencies to achieve their UK nursing registration were also supernumerary to the ward during this period and for two weeks after this was completed.

New bank and agency staff were provided with an orientation to the ward at the beginning of the shift. We saw there was a checklist in place for agency staff we spoke to which was completed by managers and nurse in charge.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates as of the end of June 2021 showed 82% of registered nurses had received an appraisal, 73% of medical staff and 95% of non-registered nursing staff. Most staff felt the appraisal was a useful process.

The clinical educators supported the learning and development needs of staff. Clinical educators in specialities such as respiratory and dialysis supported staff and signed off specialist competencies. Specialist nurses in dementia and mental health provided ward based training session to enhance skills and competence.

Managers did not always make sure staff attended team meetings but did provide access to full notes when they could not attend. Team meetings did not consistently happen across all wards. Notes of meetings that did happen were taken and stored on the ward. Daily huddles took place on most wards and notes were written to cover areas of concerns shared.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward based learning sessions took place and this was offered to bank and agency staff. Time was not always given to staff to complete mandatory training in their working hours.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Opportunities were created for staff to take on lead roles in specific areas such as falls prevention. For example, staff on ward 11 had specific link roles in learning disability, sepsis, diabetes, end of life care and mental health. There were opportunities for progression, for example, for health care assistants, who were supported to apply to the nurse associate programme. Managers we spoke to were in the process of completing leadership training sessions.

Managers did not always ensure staff received any specialist training for their role. For example, staff caring for patients receiving Continuous Positive Airway Pressure (CPAP) on ward nine, had not received training to care for patients on CPAP. Furthermore, not all registered nurses on the stroke unit had been trained to complete swallow screens which meant the service was significantly below average for the percentage of patients receiving a swallow screen within four hours of admission.

However, we saw on Ward 17, staff had undergone or were in the process of completing competencies in managing patients on non-invasive ventilation (NIV). Annual respiratory study days were facilitated for staff on ward 17. NIV machine manufacturers also provide training to staff. The stroke speciality had a study day due to take place in July 2021 which all new staff would be required to complete and yearly thereafter for updates.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us additional support was given to staff who needed more supervision in developing their skills to ensure standards had been achieved. There were systems in place, supported by the human resources department with regards to revalidation and registration with the relevant professional bodies for example nursing and midwifery council (NMC) and general medical council (GMC). Local management had oversite of the registration status of staff they line managed. Staff told us they had been supported with revalidation.

Multidisciplinary working

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

Staff generally held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Patients had their care pathway reviewed by relevant consultants. Daily consultant led board rounds took place as well as regular MDT meetings in specialities. We observed board rounds and MDTs during our inspection. These were generally well attended by a range of clinical, nursing and therapy staff as required. Therapy staff provided effective input to these meetings and their opinions were respected. The meetings covered the holistic needs of the patient such as care, treatment, safeguarding and social needs.

However, we observed one board round on ward 11 where a registered nurse was not present for the board round. Doctors told us this was a regular occurrence due to staff shortages and impacted the effectiveness of care provided as actions were not always implemented such as fluid balance monitoring.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialist staff were available to provide timely review and specialist assessment where required. For example, we saw stroke specialist nurses were available to provide timely assessment and treatment to patients identified as having a stroke. Staff were available to assist patients and staff across all disciplines including the emergency and medicine division.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. During our inspection, we saw evidence where patients had been assessed by the mental health liaison service. Staff were aware who they could contact should they need advice or support in caring for patients with mental health needs.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds happened on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. However, data provided by the trust showed the service did not always meet the 14 hours to consultant review standard. From April 2019 to March 2020, 65% of patients had been reviewed by a consultant within 14 hours of arrival to hospital. The service was unable to provide us with more up to date information at the time of the inspection.

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

intended to improve their mental health liaison so there was on-site cover out of hours as opposed to on-call access to the crisis team. Therapists told us seven-day working had negatively impacted upon patients as backfill arrangements in the week were not robust meaning, they could not deliver the care needed to all patients in line with national guidance. The occupational therapy and physio 24-hour response time was not being met. Dietitian and speech and language therapy (SALT) provided Monday to Friday service only with on call cover at the weekend.

Pharmacy services were provided to wards from 8am to 6pm Monday to Friday and from 9am to 12noon on Saturdays. A 24 hour a day, seven day a week emergency duty pharmacist was also accessible for urgent inpatients items and advice.

The frailty service was not available outside normal working hours.

Seven-day services were available in the stroke wards including physio and occupational therapy. However, SALT was only available six days a week. The service was also in the process of recruiting additional stroke clinical nurse specialists to enable effective seven-day provision.

The service did not have enough scanning capacity to enable timely access for stroke patients. For example, Computerised Tomography (CT) scanning provision was not available seven days to ensure timely access for stroke patients to receive thrombolysis. Furthermore, there were only three doppler slots available Monday to Friday for patients with a suspected Transient Ischaemic Attack (TIA). This meant patients with suspected TIA could have a delayed diagnosis or come to harm. To mitigate this, additional consultant slots had been created to enable consultant reviews within 24 hours and scans offered as outpatients.

This was a risk on the service risk register since 2018 with no resolution as the CT/radiology department did not have capacity.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service had limited information promoting healthy lifestyles and support on wards. Staff did not fully assess each patient’s health when admitted and we did not always see support from staff for any individual needs to live a healthier lifestyle. For example, we did not see evidence that staff always assessed patients’ lifestyles including smoking and alcohol use. Staff often left this section of the nursing assessment blank. We did not see evidence that any healthy lifestyle advice was given in any records we reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had completed mandatory training in mental Capacity and Deprivation of Liberty Safeguards. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Not all staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The trust set a target of 90% for completion of Mental Capacity Act (MCA) level 2 training. Up to date training compliance levels provided following the inspection showed the 90% training target was met for registered nursing staff (90%). However, the 90% target continued not to be met for medical staff who were significantly below the trust target (58%) and other clinical staff (77%).

Medical care (including older people's care)

Most staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This was an improvement since our last comprehensive inspection in 2019. Staff could demonstrate their understanding and give examples of how to apply and record assessments regarding the MCA and DoLS. We reviewed seven patient records where the patient lacked capacity and found MCA assessments and Best Interest (BI) decisions were completed and individualised to the patient. We found one record where a capacity assessment and best interests had been completed on admission but had been reviewed by the dementia team who had requested the assessment be completed. We also found evidence that mental health liaison and dementia teams reviewed patients and provided guidance to staff about managing the patient and actions they should take.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff asking patients consent to complete routine tasks such as taking blood pressure. In endoscopy we reviewed three records and found consent for procedures was documented.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed eight MCA assessments and BI decisions and found in general they contained detailed information about the patient and their wishes. The documentation was specific and detailed actions to be taken in the patient's best interests such as administering medicines and undergoing diagnostic procedures.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Consent was clearly recorded in two endoscopy records we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff explained how they would support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Assessment documentation prompted staff to raise any concerns about mental capacity. Mental health specialist nurses and dementia nurses told us they worked across both sites supporting staff with decision making.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff documented on shift handovers which patients were deprived of their liberty and we saw this was discussed at safety huddles. All staff we spoke to knew which patients who were deprived of their liberty. Staff knew when they needed to reapply for a DoLS and managers monitored this. Furthermore, the dementia team assessed patients living with dementia and we saw they provided direction and support to staff where a patient lacked capacity and required a DoLS to be in place.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Substantive staff were aware of how to access policies and procedures and they knew who to contact should they need advice and support.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Nursing quality metrics were completed monthly. MCA and DoLS documentation was audited. Audits from April 2021 to June 2021 demonstrated on average the service was 78% complaint with these expected standards which was below the trust target.

Medical care (including older people's care)

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We found this had improved since our previous comprehensive inspection on 2019. We saw staff completed DoLS applications in line with approved documentation. These were stored in patient records. We observed that DoLS renewals were completed once urgent applications had expired. It was clear from records when the urgent DoLS was due to be renewed.

Is the service caring?

Good  

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff interacted with patients and those close to them in a respectful and considerate way. We observed interactions with patients and found staff generally had a good rapport with patients. Whilst delivering care and treatment, staff took time to talk to patients about how they were feeling and respond to any queries they had. We saw staff taking an interest in patients by asking them questions about their family or how they were feeling.

Patients said staff treated them well and with kindness. We spoke to seven patients who all spoke positively about staff. For example, patients used words such a ‘lovely’ and ‘kind’ to describe staff. One patient told us staff would sit with a patient who was agitated and confused and helped to calm them down.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient. We saw staff showed understanding and a non-judgmental attitude when caring for patients with challenging behaviours. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed curtains being drawn around patient beds by doctors when having conversations with patients and side room doors being closed. Staff told us they could utilise meeting rooms should they need to have sensitive conversations with patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. However, the quality of interactions was not always consistent. We observed agency staff interactions with patients when providing enhanced supervision, were not as engaging with patients as were substantive staff. On two occasions we observed limited and task focused interactions from staff to a patient on enhanced supervision. The interactions were not always engaging, or person centred. However, we recognise that on these two occasions staff had not worked on the ward or with the patient before.

In general, we observed staff interacting with patients including patients who were confused. Staff generally provided reassurance and took time to talk to patients despite being very busy. Patients told us staff were kind and told us they spent time interacting with other confused patients when required.

Medical care (including older people's care)

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff providing one to one care to patients who were displaying challenging behaviour. We observed positive interactions, use of conversation and attempts to be as least restrictive as possible as well as ensuring the safety of all patients. We saw health care assistants were utilised to provide one to one care. Staff generally understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Clinical nurse specialists were employed who supported patients through their treatment pathway. Chaplin support was available 24 hours a day seven days per week and staff could access them through the hospital switchboard. Holy communion took place every Sunday and this was able to be received on the wards for those patients not able to attend. Prayer facilities were also available for Muslim worshippers.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Therapists worked together with patients to identify and agree joint goals to set for treatment outcomes. Specialist nurses took time to meet patients to discuss their treatment, providing emotional support in dealing with their condition. Staff talked with patients, families and carers in a way they could understand. Staff were able to access interpreting service for patients whose first language was not English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, on ward 15 we saw 'as a result of your feedback' boards which listed feedback and what the ward had done to improve. Ward 15 had implemented a relative communication folder and appointment system for relatives to speak to nursing and medical staff following feedback family were struggling to speak to staff.

Patients gave positive feedback about the service. Leaflets were displayed for patients and relatives to read about how to make a complaint and share their views. Family and Friends Test (FFT) cards were given to patients at the point of discharge. We saw each ward displayed their FFT results which were updated for May 2021. For example, 100% patients who had completed them on ward 16 and 17 in the Month of May said they would recommend the service to family and friends. Following the inspection, the service provided us with their Friends and Family Test (FFT) performance from July 2020 to June 2021. All wards and units scored 94% or higher on an annual basis. However, due to the COVID-19 pandemic, data was not submitted every month. All wards within the medicine division scored 100% in June 2021.

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

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

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

Managers planned and organised services, so they met the changing needs of the local population. The service worked with local organisations and the wider system to identify needs of the local population. Improvements had been made to respond to the needs of the aging population. Frailty assessments were completed for patients referred and we saw

evidence the frailty team had contact with patients to support their care and discharge needs. The service worked alongside community services to support 'Home First' discharge planning. The frailty assessment team aimed to improve care and reduce the length of stay and readmission rates for elderly patients with complex medical needs. The stroke services had expanded to seven days to offer improved therapy support to patients to improve quality outcomes.

The service relieved pressure on other departments when they could treat patients in a day. Same Day Emergency Care (SDEC) operated within the acute medical unit. SDEC aimed to ensure patients were treated by a senior clinician in the most suitable environment to support their needs and reduce the impact on the emergency department. During our inspection we saw patients were referred into these areas from ED for lower acuity and ambulatory patients.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Wards and departments were designed in a way to provide single sex accommodation. No single sex breaches were observed during our inspection. The hyper acute stroke unit had improved its process since our previous inspection in 2019 to ensure no single sex breaches. However, 11 single sex breaches were reported on the coronary care unit from April 2021 to June 2021. These were due to delays in being able to access a step-down bed following a period of high intervention care and the patient then waiting for a bed within the normal medical bed provision.

Most facilities and premises were mostly appropriate for the services being delivered. However, we continued to observe limited adaptations to the physical environment to support patients living with dementia.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Whilst the mental health liaison service did not provide out of hours cover, there was a pathway into the crisis intervention service to support any patient requiring support. There was a plan to increase the provision to 24 hours at Princes Royal Hospital in line with provision at Royal Shrewsbury Hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service provided a dialysis service six days a week. The service provided a Hyper Acute Stroke Unit (HASU) which enabled urgent assessment, treatment and monitoring of patients who had experienced a stroke. Thrombolysis was offered 24 hours a day from a specialised room within the stroke unit.

Meeting people's individual needs

The service did not always take into account patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients were assessed on admission to identify any additional support or needs. A dementia support team was in place led by a dementia clinical specialist. As a part of the dementia screening process they would routinely screen all patients who were 75 years and older within 72 hours of admission.

A dementia friendly hospital charter and action plan was in place. Processes to identify patients living with dementia included a butterfly sticker in patient records, a butterfly magnet on bedside boards and also on electronic patient at a glance board. We saw these were generally in place. However, an audit from 01 April 2021 to 31 April 2021 found 28 out of 34 patients living with dementia did not have the butterfly box selected on the bedside board.

The service had activity boxes in place to support patients living with dementia. However, we did not see evidence these were used during our inspection or that all staff knew about them.

Medical care (including older people's care)

We reviewed the records of ten patients living with dementia. We found staff did not complete a full and holistic assessment of need for eight of these patients. For example, we found the patients communication needs were generally not assessed. In one record a staff member documented 'dementia' in answer to problems the patient had which were associated with the communication barrier. This meant patients communication needs were not fully assessed.

Patients were assessed by the dementia team, however, the outcome of this was a sticker of actions to guide staff how to care for the patient. Specialist staff used a highlighter to draw attention to staff actions they should take. For example, to complete a mental capacity assessment, support with meals and fluid intake. There was limited evidence of the patient's individual needs being outlined and care planned in a personalised way. We did however see good practice in response to a patient being assessed by the mental health service who provided ward staff with a very detailed outline of the patients' personal needs. This included a communication plan and guidance for staff to support the patient where their behaviour changed.

Generic care plans were used by nursing staff which meant patients living with mental health problems, learning disabilities and dementia did not always have their identified or individual care needs recorded.

Wards were not always designed to meet the needs of patients living with dementia. Not all wards we visited had security access in and out which meant that patients who were confused were at risk of leaving the ward unattended and being exposed to potential harm. We also found most dirty utility rooms did not have a lock which could pose a risk to vulnerable patients.

We observed dementia clocks were not always visible. The dementia charter included an action for all orientation clocks to be within sight of all patients, including the hospital name. During our inspection there was limited evidence this was consistently in place across all wards, however, there was an action for this to be in place by September 2021.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Four out of ten patients who were living with dementia had a 'this is me' document visible at the bedside. Without the details of the individuals needs and preferences the service would be unable to provide personalised and compassionate care that met each individual's needs.

A learning disability liaison service was available. One staff member was available onsite to assess patients living with a learning disability and ensure their needs were being met.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff told us they could access information online or use google translate. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment but did not always use them. Managers told us communication books were available to staff to support patients to communicate their needs, however, we did not see these being used during our inspection.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Medical care (including older people's care)

Managers monitored waiting times and made sure patients could access services when needed. However, patients did not always receive treatment within agreed timeframes and national targets.

Incomplete Referral to Treatment (RTT) pathways

As of April 2021, the trust had the fifth lowest proportion (55.1%) of patients on incomplete pathways who had waited less than 18 weeks, out of the 21 non-specialist acute trusts in the midlands. This was lower than the overall Midlands performance and considerably lower than the overall England average. The trust had 3,295 patients on incomplete pathways waiting more than 52 weeks for treatment. The trust had no such waits from November 2019 to February 2020. However, during the COVID-19 pandemic the number increased considerably. New data received following our inspection and published on 8 July 2021, showed the number of incomplete pathways where the patient had been waiting more than 52 weeks reduced to 2,925 in May 2021.

Complete Referral to Treatment (RTT) pathways

As of April 2021, the trust had the twelfth lowest proportion of patients on complete admitted pathways who had waited less than 18 weeks, out of the 21 non-specialist acute trusts in the midlands. This was similar to the overall Midlands performance and England average. There was a considerable improvement in performance from October 2020 to January 2021. However, this had subsequently deteriorated.

The number of patients waiting more than 52 weeks for treatment over time on completed admitted pathways fluctuated and as of April 2021 the trust had 154 patients waiting more than 52 weeks. The service had been working through a backlog of exceptionally long waiters as a result of the COVID-19 pandemic and continued to increase capacity to improve performance and access to treatment.

The risk of not meeting the operational standards was on the trust risk register. The service had implemented processes to review all patients and undertake harm reviews where required.

Managers and staff worked to make sure patients did not stay longer than they needed to. From March 2020 to February 2021 the average length of stay across all medical specialties was similar to or lower than expected based on the England average, for both elective and non-elective admissions. Over this period the average length of stay for elective cardiology at Princess Royal Hospital was higher than expected based on the England average. The same was true of non-elective cardiology. Daily multidisciplinary board rounds ensured there was daily progress updates on care and treatment to identify treatment delays so that time in hospital was optimised.

The trust had a ‘Sath2Home’ service which was a domiciliary care bridging service which allowed patients to return home if their care could not be sourced in a timely manner. The service supported the reduction in length of stay (LOS) by facilitating discharge at short notice to ensure patients were discharged in line with national discharge guidelines.

The service moved patients only when there was a clear medical reason or in their best interest. Staff told us where possible they avoided moving patients, particularly patients with complex needs. However, staff told us at times of high pressure, patient were sometimes moved to accommodate new admissions. For example, where patients were medically fit, they were sometimes moved when a specialist bed was required for another patient. Managers monitored that patient moves between wards. However, it was unclear how this was used to reduce the number of bed moves. Data provided to us following the inspection showed between January 2021 and June 2021 there was ranging between 1023 and 1208 moves monthly. Records did not include the rationale for moving a patient.

Staff moved patients between wards at night. Data provided to us following our inspection demonstrated that from January 2021 to June 2021, 1949 ward moves occurred from 10pm to 7am. This accounted for 29% of all bed moves. We were concerned patients living with dementia had been moved at night which is disorientating and can lead to harms such as emotional distress and falls. This was a continued concern raised in our 2018 and 2019 inspections as we were concerned individual patients needs were not being considered or met due to moves between wards and moved for clinical or non-clinical reasons.

Frequent night moves may also be indicative of poor flow planning in the day. Ward moves should be limited per admission with night moves being avoided unless essential for the person's care.

Managers and staff worked to make sure that they started discharge planning as early as possible. Daily board rounds took place with nursing, therapy, medical staff as well as patient journey facilitators. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had six patient journey facilitators based on wards Monday to Saturday. They supported the ward with all aspects relating to the patient journey and blockages to discharge. For example, arranging transport, following up outstanding diagnostics, ensuring discharge summaries and take-home medicines are ready, liaising with families and care providers and external stakeholders.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. From November 2020 to May 2021, the percentage of delayed discharges fluctuated over time. As of May 2021, the percentage of delayed discharges across the trust was 55.5%. Compared to other trusts in the Midlands region, the percentage of delayed discharges over time has been better than most trusts.

The service monitored stranded (those in hospital more than seven days) and super-stranded (in hospital more than 21 days) patient numbers. Managers had regular meetings to discuss progress with blockages to discharge for these patients and ensured board rounds were used effectively to optimise admissions to hospital.

Weekly meetings were held to review all stranded and super-stranded patients in the hospital. This enabled staff to work in a targeted way with patients who were not medically optimised for discharge. This included support for the clinicians from the medical directors to unblock or remove barriers and working with system partners to flag patients who required escalation to support their discharge. The service worked with system partners to address community blockages to discharging these patients who may be waiting for a social care package.

Managers worked to minimise the number of medical patients on non-medical wards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Most patients we spoke to were aware how to complain should they have any concerns. Matrons completed weekly audits which included speaking to patients to gather feedback about care and treatment. The service clearly displayed information about how to raise a concern in patient areas. Information was displayed on ward notice boards and on the trust website. Leaflets were available to patients which outlined how the trust dealt with complaints and how to complain.

Staff understood the policy on complaints and knew how to handle them. The trust had a complaints policy and staff knew how to access the policy. Staff we spoke to said they would initially try to resolve any complaints received. Staff were familiar with the process for escalating complaints to either their manager or signposting patients and their relatives to the patient advice and liaison service (PALS). Out of hours, staff could escalate complaints to the site manager.

Managers investigated complaints and identified themes. We saw examples of complaint investigations and outcomes of complaints which demonstrated managers thoroughly investigated complaints. At ward level, managers collated themes and trends from complaints and used these to improve services.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigating complaints were aware of the timescales to provide initial feedback to patients to acknowledge the complaint. We reviewed three complaints and saw complainants were provided with an outcome letter including an overview of their investigation and apology. However, during our inspection, managers told us there was a backlog in concluding complaints. As a result, the medicine division was in the process of implementing a revised process to ensure complaints were responded to and investigated in a timely manner and managers had oversight.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed at divisional governance and matron meetings. Staff told us they received feedback in daily huddles from any complaints received and actions to improve to avoid further complaints.

Staff could give examples of how they used patient feedback to improve daily practice. We saw staff had implemented a communication sheet following feedback and complaints during the COVID-19 pandemic that relatives had not been sufficiently communicated with. These sheets contained information to communicate with relatives and to record conversations clearly. An appointment system was set up so relatives had set times to call in.

At the end of 2020 managers noticed there was a trend in patient complaints that showed staff were not working in a joined-up way. As a result, staff instigated an afternoon huddle, attended by the multidisciplinary team where all patients on the ward were discussed to helps staff approach the patient holistically. This also heled improve management of discharge.

Is the service well-led?

Requires Improvement ↑

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

Leadership

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

Changes had been made to the senior leadership team since our last comprehensive inspection in November 2019. The medical care core service sat within the trust emergency and acute medicine division. The division was strategically led

by a triumvirate made up of a divisional director of nursing, divisional medical director and centre managers. The senior leadership team worked well together, and we received positive feedback from staff throughout the inspection that the new divisional leadership team provided more direction and was more visible and responsive. Several staff commented they had confidence in the new structure and recognised improvements were being made.

Local leadership was provided by matrons and ward managers. Most staff told us matrons were visible, supportive, and approachable. Staff told us if their matron was away, another matron visited to check on issues and any support required. Managers told us there was a matron on call seven days a week. In addition, quality matrons were visible on wards daily supporting staff with key areas of development such as falls prevention.

Senior leaders had prioritised and invested in developing the management structure in the division. A leadership training programme had been implemented. Work had been undertaken to improve the skills, competencies and joined up working of matrons. This included an away day aimed at team building and planning for improvements. Matrons had taken on lead roles in specific areas to improve clinical leadership. Some examples of lead roles included tissue viability, documentation, nutrition and hydration, safeguarding, mental capacity, mental health and restrictive interventions. A second away day was planned for October 2021.

Ward managers had started leadership courses and valued the investment in their development. which made them feel appreciated and more connected to the trust.

Specialist nurses provided advice, support and direction to staff in specific specialities such as stroke, mental health and dementia. Staff told us these staff members were more visible on the wards.

Vision and Strategy

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

Leaders had a clear vision of what they wanted to achieve and understood the need to work closely with other divisions across the trust to achieve its objectives. The strategy was plainly set out and easy to understand. There were eight strands to the strategy including: achieving for our patients, keeping great people, engagement and wellbeing, people development and leadership, support and belonging, attracting people, transforming the trust and equality, diversity and inclusion. A people plan had been produced which mapped out key priorities to achieve the trusts eight priorities.

Staff were involved in the formulation of the strategy which set out a ‘PACT’ (Partnering, Ambitious, Caring and Trusted) with staff outlining how they intended to support management and staff to improve safe patient care. The strategy identified a range of quality metrics and a milestone action plan to measure success. Progress against these were reviewed at monthly meetings. Senior managers reported on progress against achieving their strategic objectives through quality and performance reports to the divisional board.

The service was in the process of applying the priorities along with their values and behaviour framework across the division. A behaviour framework had been produced based on staff feedback. All wards and departments in the division had been tasked to self-assess themselves against the framework and we saw evidence this was underway or had been completed in most areas. Following the inspection, the service sent us examples of how different specialities had adapted the framework to their service to make it relevant.

There was recognition that effective communication was vital to help drive change within the service to build reputation. This resulted in a divisional communication plan aimed at making sustained changes, building trust and understanding. The plan outlined how the leadership team intended to embed the strategy and how they were going to communicate with staff. Local managers and most staff we spoke to understood some of these strategic objectives, However, staff were not always aware of the trust vision and values when asked.

Leaders had invested in external work to ensure services are sustainable and aligned to local plans. This included public engagement and engagement from local services and commissioners. For example, work was underway to restructure cardiology services to create improved and integrated pathways locally. Senior leaders were involved with the newly formed Integrated care System (ICS), contributing to the management of resources locally to improve the health of the local population. Outcomes of the meeting communicated to managers at the divisional huddle.

Culture

Staff did not always feel respected, supported and valued. However, most staff recognised improvements had been made. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff did not always feel supported, respected and valued but most staff felt improvements had been made. Service leaders told us staff wellbeing and morale was one of their top priorities and had a plan in place to improve this. For example, there was limited places for staff to take breaks. The service had created a garden area for staff and patients to go in the summer and were investing in developing indoor space. Most staff confirmed there had been investment in staff wellbeing and development since our previous inspection.

International nurses recruited since our previous inspection in 2019 generally liked working at the trust. However, initially it was a difficult transition, particularly those who started during the COVID-19 pandemic. Some managers told us the first cohort of international nurses were not supported initially to integrate into the service. This was escalated and the Freedom To Speak Up Guardian (FTSUG) was involved in addressing some concerns. This resulted in improvements being made and an improved induction including support with non-work activities such as assistance with accommodation. An international nurse lead and worked alongside the trust FTSUG and assigned nurse ambassadors to support new international nurses.

Locum doctors told us they did not always feel supported by the service as they were not included in communications and meetings other than ward rounds and multi-disciplinary team meetings.

Therapy staff told us they felt the service was improving, however, staffing levels impacted. Therapy staff felt they were unable to provide a good service due to being stretched to cover seven days. Whilst improvements were acknowledged in the more joined up approach of working, some therapy staff did not feel their roles were as valued.

Most staff commented the culture had improved within the service. For example, work had been undertaken to improve staff wellbeing and safety culture on ward 15 and 16. A new ward manager had been recruited providing leadership, engagement and support to staff. During our previous inspection ward 10 and 11 were cited as an area of concern. Staff raised concern about the culture. During this inspection, most staff appreciated work had been done to address cultural concerns and they had seen some improvements. Continuity of leadership had remained an issue on ward 10, however, staff were positive that improvements had been made and more staff were brought in. Staff vacancies remained an area for concern impacting on staff morale. Managers and staff acknowledged whilst progress had been made, further improvements were required to continue to improve the culture.

Medical care (including older people's care)

We reviewed the 2020 NHS staff survey results for the medicine division. In general, the service performed worse than average. The service performed worse in the 'safety culture' measure and had done for the three years prior. Five areas were below average including: health and wellbeing, quality of care, safe environment and bullying, staff engagement and teamwork. There was an improvement action plan based on the staff survey results which had been presented to staff. The service did not provide evidence of its progress in achieving the actions highlighted in the plan. The triumvirate were focused on investing in the workforce and addressing behaviours to shift the culture.

The culture was centred on the needs and experience of people who use services. Leaders recognised the importance of creating a healthy and engaged workforce in improving the quality of care provided to patients. Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority.

The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders told us they had been working to improve the culture of openness and transparency throughout the division. Leaders recognised this work was still on-going. Most staff felt able to report concerns to their managers, but they also had the option of the freedom to speak up guardian (FTSUG) route. Drop-in session with the FTSPGs took place across the division. Staff on ward 11 had a recent drop-in session and felt this was helpful and useful to share concerns and ideas to improve. FTSUG reports demonstrated an increase in the numbers of staff approaching them which reflected leaders providing more opportunities for transparency and feedback. Various actions had been taken to address these concerns including escalation, involvement of human resources, mediation, values and behaviours workshops and roll out of a trust wide cultural programme 'Making a Difference Together'.

There was information displayed on the ward advising staff how to raise a concern. This suggested the trust had an 'open culture' in which staff could raise concerns without fear. All staff we asked understood the trust policy and would feel comfortable using it if necessary.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us there were opportunities for progression including taking on lead roles, leadership training and opportunities such as the nurse associate programme.

Governance

Leaders did not always operate effective governance processes; however, the service had made improvements. Staff at all levels were clear about their roles and accountabilities. Opportunities to meet, discuss and learn from the performance of the service was inconsistent.

There were governance frameworks in place to provide oversight of quality and safety performance, however, we were not assured they were sufficiently robust in consistently maintaining standards. Nursing quality audits were completed monthly and the findings were discussed at weekly meetings between matrons and ward managers and monthly confirm and challenge meetings led by the deputy director of nursing. Quality performance issues were raised, and the quality matrons worked with ward managers to identify actions for improvement. We found that there was consistently poor performance in some nursing quality metrics which had not improved despite the agreed actions. For example, fluid balance monitoring and pressure care. However, we did see some improvements where there had been a drive such as compliance with mental capacity assessments, Deprivation of Liberty Safeguard (DoLS) documentation and escalation of deteriorating patients.

Systems and processes for implementing learning following incidents was not always effective. For example, we saw actions to improve pressure care following serious incidents, however, during our inspection we found poor compliance with processes to prevent patients developing a pressure ulcer.

Service leaders told us the governance processes had changed and significantly improved to enable better ward to board reporting and accountability. However, leaders recognised there is still improvements to be made in embedding effective processes to capture learning and embed changes. For example, leaders recognised the governance around complaints in the division required improvements to ensure complaints were dealt with appropriately, responded to within trust policy timescales and learning fully embedded.

Clinical and divisional leaders attended monthly divisional meetings where senior managers discussed performance, quality, risk, governance and human resources. Arrangements supported the cascading of information from board to ward level. For example, the medicine and emergency care division committee meeting took place monthly. These were attended by senior leaders and information was cascaded down to divisional matron and ward manager meetings, medicine safety huddles and ward meetings and daily ward safety huddles. During our inspection we saw examples of ward meeting minutes and daily huddle information sharing. However, ward meetings were irregular and varied in quality and content. We were therefore not assured all staff received information in an aligned, consistent and timely manner.

Speciality governance meetings took place and were well attended. These covered performance, quality and mortality reviews. We saw there were processes in place to align these to divisional meetings.

Leaders recognised they struggled to embed changes due to the volume of temporary staffing. The service had improved communication with staff through agency by creating and regularly updating a trust induction booklet with information required to work on wards. For example, where there was learning from serious incidents, this had been included. Agency nursing staff were also involved in ward-based training sessions and meetings. However, we were concerned medical locum staff did not have access to systems to enable them to receive important risk and safety information. Therefore, we were not assured the governance systems were always effective in communicating with locum doctors.

Management of risk, issues and performance

Not all risks were identified and escalated so that actions to reduce their impact were implemented. Leaders and teams did not always use systems to manage performance effectively.

Divisional risk register review and oversight processes were not always effective. It was unclear who had oversight of the risk registers. Managers we spoke with were generally unable to tell us what was on the service risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. We reviewed the medicine and emergency care divisional committee minutes for 26 February 2021. The number of new risks was discussed but there was no evidence that the risks were reviewed or that existing risks were considered. It was documented that leaders did not have assurance risks were being added appropriately as there was no Operational Risk Group (ORG). Divisional leaders we spoke to during our inspection acknowledged improvements were required to improve the process. Leaders had reviewed the process and intended to train local leaders to understand and review the risk registers that related to them and implement a process for feeding into divisional meetings. After the inspection, the trust told us that the division met bi-monthly to review the risk register and update the live register with updates on actions and mitigations. These meetings were not minuted, but oversight of risks went to the divisional operational group quarterly for oversight.

We reviewed the risk register following our inspection. We found they did not identify all risk issues we observed during our inspection such as environmental risks in bay A on ward 10, lack of side rooms for isolation and poor compliance with swallow screening and assessment. These were known risks yet not on the risk register or risk assessed, therefore, we were not assured risks were effectively mitigated.

Managers recognised staffing was the major risk to the service and the hospital. There were recruitment and retention initiatives in place to attempt to mitigate the risk. Overseas recruitment, close working with the deanery and securing additional finances had all proved successful. However, it was recognised there were still vacancies in key roles and continued reliance on agency staff.

Incidents were not always investigated in a timely manner meaning there were potentially missed opportunities for shared learning. A system was in place to track serious incident investigations and progress made. We reviewed the tracker which showed not all incidents were reviewed in a timely manner, meaning learning from these incidents could not be identified, shared and implemented.

A nursing and quality performance dashboard was in place which included outcomes from audits, patient safety outcomes, infection prevention and control compliance, medicines management audits, training and staffing data. This was used by the division to monitor performance. Managers told us they had regular meetings with their matrons and divisional director of nursing to discuss ward performance and set actions for improvement. This data was incorporated into the integrated performance report which went to the trust board and quality and safety board. We saw ward individual performance was displayed on most wards we visited.

Performance in national audit outcomes was not integrated into the governance structures to ensure management oversight. There was a lack of interface between patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we did not see evidence of consideration of patient outcomes and monitoring of improvements plans in governance and committee meetings. Whilst specialities reported into these meetings, they did not provide updates on progress.

We were not assured there was effective oversight of the Sentinel Stroke National Audit programme (SSNAP) improvement plan. We did not see this reported on in divisional meetings minutes we reviewed, and we saw most actions had been on the action plan for more than two years with no resolution. The service was ineffective in addressing gaps in provision such as radiology department capacity to enable Computerised Tomography (CT) scanning within the hour.

Information Management

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff did not always have access to clinical information in a timely manner. Junior and locum doctors told us the service did not provide them with access to electronic systems as soon as they started and had to wait to be granted access. This meant they used colleagues' details to access electronic systems. Locum doctors told us they did not have access to trust communication platforms such as email which meant they did not receive important safety updates and were often missed out of meetings where information was shared. This was not on the service risk register. However, service leaders told us there had been some staffing turnover in the medical staffing team which may have impacted this.

Information technology systems were used to monitor patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finance. Access to all electronic systems was secure and required password access.

There was an electronic system that recorded patients' observations and allowed nursing staff to monitor change over time. This data was automatically uploaded to the electronic performance dashboard system. All safety and quality

audit performance was recorded on the electronic performance dashboard which ward managers had access to. Performance outcomes were RAG rated to identify areas of compliance and concern. Managers could see their own ward performance information as well as that of other wards so it could be compared. The dashboard tracked performance over time and enabled staff to identify any areas of worsening performance.

The trust shared data securely with us and other agencies in accordance with legislation. Serious reportable incidents were reported to us when they occurred in line with the National Reporting and Learning System (NRLS) as required.

Engagement

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

Most staff and managers said there had been many opportunities to feedback to senior managers and trust wide managers. Managers held drop-in sessions for engagement so that staff felt listened to and able to raise concerns. Freedom to speak up guardians had offered drop-in sessions to increase opportunities for engagement with staff. Examples of actions taken following engagement is plans to improve staff break areas and put air conditioning in place in specific areas to improve staff wellbeing.

The freedom to speak up guardian reports to the board demonstrated staff were speaking up including junior doctors, therapy staff and nursing staff.

Managers used the values and behaviour framework to engage with staff. Staff had opportunity to contribute to the framework and identify acceptable and unacceptable behaviours.

Patient feedback was collected and used to shape services. For example, the service used the friends and family test (FFT), local inpatient surveys, 'gather' (matron and senior nurse weekend checks) and exemplar feedback to gather information on patient experience of the services the hospital provided. In addition, patients could provide feedback through the feedback hub on the trust website through submitting a feedback form, sharing their story (through text, audio and video options), completing an FFT survey online, or raising a concern or sharing feedback. There was a patient experience team who produced quarterly reports that collated all patient feedback along with any themes from complaints and compliments. The report was presented to board and widely shared with staff across the service. It identified learning and any actions required from the feedback. Priorities for next steps to improve patient experience were also highlighted.

The trust engaged with key stake holders through attendance at council meetings in the development of their operational plans and local strategic initiatives. There was regular engagement with the local clinical commissioning group to review the service delivery to ensure it was satisfactory and met the needs of the local population.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, there were areas identified for improvement at our last inspection which were still of concern.

Staff of all roles and levels were committed to making improvements. The service leaders as a team were in their infancy but recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service. Leaders engaged staff when making improvements.

Medical care (including older people's care)

During our inspection we found there were some improvements since our previous inspections in 2019 and 2020. For example, staff felt more supported by senior management. There were improvements in the completion and quality of mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards. We also saw evidence of improved compliance with some trust risk assessments such as nutrition and falls risks assessments. There was also more focus on supporting patients living with mental ill health and dementia. However, we found there were continued breaches consistent with findings in previous inspection and serious incident investigations. For example, we found there were continued concerns with risk assessments, personalised care planning, implementation of the falls care bundle, continued examples of bed rails being used when contraindicated and lack of demonstrable and consistent learning from incidents. Whilst improvements had been made at all levels within the service, the pace at which the improvements were being made was slow and raised concerns of on-going risk of harm to patients.