Shrewsbury and Telford Hospital NHS Trust

The Royal Shrewsbury Hospital

Quality Report

Mytton Oak Road
Shrewsbury
SY3 8XQ
Tel: 01743 261000
Website: www.sath.nhs.uk

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

Ratings

Overall rating for this hospital

Urgent and emergency services	

Summary of findings

Letter from the Chief Inspector of Hospitals

This was a focused inspection to review concerns relating to the emergency department. It took place between 9am and 4pm on Tuesday 16 April 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection. We also inspected the Princess Royal Hospital as part of this inspection. Due to the nature of services and same leadership team, there are similarities across both location reports.

Our key findings were:

- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- Provision for children was limited, in part due to the consolidation of children's services to The Princess Royal Hospital. Clinical oversight of children in the department was limited, with poor line of sight of the children's waiting area for example.
- Streaming processes were limited and lacked appropriate standard operating procedures. There was limited clinical oversight of the adult waiting room which meant patients were at risk of deteriorating without being noted by clinical staff.
- We noted an occasion when non-clinically trained staff directed a patient away from the emergency department without retaining any record of contact with the patient.
- Compliance against constitutional standards remained a challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.
- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.

As a result of this inspection, we opted to utilise our enforcement powers and imposed urgent conditions of the Provider's registration. Namely,

1. The registered provider must ensure that within three days of this notice, it reviews and implements an effective system with the aim of ensuring that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.
2. The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately.
3. The registered provider must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival.
4. The registered provider must provide the Commission with a report setting out the steps it has taken to implement the system as required in conditions two to three, within five days.
5. The registered provider 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.
6. From 26 April 2019 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing the system in place for effective management of children through the emergency care pathway. The report must also include the following:

a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

Summary of findings

c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

1. The registered provider must ensure that within three days of this notice, 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.
2. The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.

The trust must also ensure

They operate an effective clinical governance process which is supported by reliable and tested information and datasets.

Ensure staff receive feedback on incidents and outcomes from morbidity and mortality reviews.

Ensure staff comply with local hand hygiene and infection control protocols.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure. We did not inspect any other core service or wards at this hospital. During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry. We did not rate this service at this inspection. We did not inspect the whole core service therefore there are no ratings associated with this inspection. We found that: • Provision for mental health patients was not consistent with national best practice standards. The environment in which patients presenting with mental health conditions had not been risk assessed, despite this being noted as an area for improvement following our previous inspection. The environment continued to present risks including ligature points. • The initial management of patients who self-presented was poor. Health professionals deviated from the trusts standard operating procedure for the streaming of patients. This meant patients experienced significant delays in having a full clinical assessment which should have occurred in a timely way as defined by national standards. • The management of children was poor. Increased demand for services meant children were leaving the department without being seen and without having received appropriate clinical assessments. • The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these. • Compliance against constitutional standards remained a challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.

Summary of findings

- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.
- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.
- Morale remained low although it was reported to be improving.

The Royal Shrewsbury Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

Contents

Background to The Royal Shrewsbury Hospital

We carried out an unannounced focused inspection of the emergency department at Royal Shrewsbury Hospital on 16 April 2019, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry and we did not rate this service at this inspection.

We previously inspected the emergency department at Royal Shrewsbury Hospital in August 2018. We rated it as inadequate overall and opted to use our urgent enforcement powers to ensure prompt action was taken to address concerns identified during the inspection.

Following this most recent inspection, we again took urgent action to ensure the provider took swift action to address system failings in relation to the triaging and continued clinical assessment of all patients who presented to the emergency department.

Our inspection team

The team that inspected the service comprised of Zoe Robinson, Inspection Manager, one other CQC inspector, a national professional advisor with expertise in urgent and emergency care and an emergency department matron specialist advisor. The inspection was overseen by Victoria Watkins, Head of Hospital Inspection.

Urgent and emergency services

Safe	
Responsive	
Well-led	
Overall	

Information about the service

The Emergency Department (ED) provides services 24 hours a day, seven days a week. There were approximately 61,034 attendances between August 2017 to July 2018 of these 9,684 attendances were children under the age of 16 years of age.

The ED consists of a waiting area, resuscitation area with four resuscitation bays and a dedicated cubicle for paediatric patients, 12 majors' cubicles, a "pit stop" or rapid assessments and treatment (RAT) room and a minor treatment area with three treatment cubicles. The department is also a recognised trauma centre.

Streaming and initial triage took place within the reception area, with a triage room off the main waiting room, that could be used for a more private triage to take place. Usually there were two qualified nurses available to at the reception or based in the waiting area, to assess the needs of patients when they arrived at the ED.

There was one area for 'fit to sit' patients which had chairs where patients, who were well enough, could sit and await discharge or further assessment.

There is also a walk-in centre located adjacent to the waiting area. This facility is managed separately and is staffed by general practitioners (GP's) and support staff.

The ED at Royal Shrewsbury Hospital was last inspected by CQC in August 2018 as part of the comprehensive hospital inspection programme; at that time, urgent care services were rated as 'Inadequate'.

During the inspection we spoke with 13 staff members which included doctors, nurses, healthcare assistants (HCAs), housekeeping staff and members of the trust executive team. We looked at 22 sets of patient records. We spoke with seven patients about their care; and spoke with eight relatives/ carers who accompanied patients who attended during our inspection.

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection. We found that:

- Provision for mental health patients was not consistent with national best practice standards. The environment in which patients presenting with mental health conditions had not been risk assessed, despite this being noted as an area for improvement following our previous inspection. The environment continued to present risks including ligature points.
- The initial management of patients who self-presented was poor. Health professionals deviated from the trusts standard operating procedure for the streaming of patients. This meant patients experienced significant delays in having a full clinical assessment which should have occurred in a timely way as defined by national standards.
- The management of children was poor. Increased demand for services meant children were leaving the department without being seen and without having received appropriate clinical assessments.
- The department implemented patient safety initiatives including early warning systems and patient safety checklists however staff did not consistently use these.
- Compliance against constitutional standards remained a challenging. Local escalation protocols failed to deliver the necessary action to decompress the emergency department.
- There remained a focus on delivering performance and avoiding twelve-hour breaches as compared to providing holistic care to patients; this was compounded by continued challenges around bed capacity and the estate.

Urgent and emergency services

- Whilst clinical governance processes existed, the information used to provide assurance was not sufficiently robust.
- Morale remained low although it was reported to be improving.

Are urgent and emergency services safe?

Environment and equipment

- The congested nature of the department meant patients could not always be nursed on hospital beds whilst they remained in the emergency department once a decision to admit had been made. This was due to the limited space within the department which restricted the use of hospital beds due to the narrow corridors and limited space in cubicles. We observed this during the inspection when we noted one elderly patient having remained on a trolley for a period of approximately twelve hours, therefore increasing the patients risk of skin damage through poor pressure relieving practices. Commentary in the patient's notes reported they had struggled to sleep overnight whilst in the department due to being uncomfortable because of the trolley they were resting on. Although the patient had an emergency department safety checklist filed in their notes, there was no reference to the patient having been supported to be repositioned or placed on a pressure relieving device or air mattress to reduce the risk of pressure damage from occurring and to ensure the patient was more comfortable. When we spoke with the patient on the morning of the inspection, they remained on a trolley and reported remaining uncomfortable.
- We spoke with five patients who were being nursed on the corridor. Each patient had attended the department alone and so had no visitors with them. Nursing staff and health care assistants were present to monitor the patients however there were periods of time when no health professionals were present. The lack of a call bell or other method or seeking help in an emergency presented a risk to those patients being cared for along the main corridor.
- The department had a separate waiting area for children. This area was unsupervised and had no clinical line of sight from any health professional. This meant there was a risk child could deteriorate without being observed by clinical staff.
- Staff had access to a sepsis trolley which was in the major's department. The trolley contained step by step guidance and all the items required to deal with a suspected sepsis patient quickly, for example, medicines and fluids. A junior doctor was identified

each day to carry a dedicated sepsis bleep. This doctor was responsible for responding to any patient who was identified as being potentially septic, in order that timely treatment could be commenced.

- Emergency equipment was checked daily and staff were aware of the trolleys locations around the emergency department.

Assessing and responding to patient risk

Risks to patients were not always assessed and their safety was not consistently monitored and managed so they were supported to stay safe.

- Patients who self-presented to the department where initially booked with a member of the administration team before then joining a second queue to see the triage and streaming nurse. The nurse took a brief clinical history to determine the most appropriate treatment pathway for the patient. Due to the location of the streaming nurse being co-located at the reception desk, it was not possible for the nurse to undertake physical observations of all patients, therefore it was not possible to fully complete the triage assessment tool used by staff in the department. Where the clinical judgement of the nurse considered it appropriate, a healthcare assistant would be asked to complete physical observations on patients; there was no standard operating procedure or other formalised process by which this would take place and rested solely with the assessing nurse's experience and judgement.
- Similar to the arrangements at The Princess Royal Hospital, there was an expectation that patients who felt unwell whilst waiting to be seen, should report back to the triage nurse to escalate their concerns. There was no standardised process for reviewing patients once they had initially been seen by the triage nurse. This was despite there continuing to be challenges with flow through the department and so some self-presenting patients continued to experience delays in being seen by a clinician, or of having any formal initial clinical assessment. This meant there was some risk patients could deteriorate in the department without any health professional intervention unless the patient or others recognised the patient as deteriorating.
- During the inspection, we observed a patient attempting to book in with a member of the reception staff. The patient presented with swelling to the face; the receptionist was observed to advise the patient that dental cases could not be seen or treated in the department and that the patient should refer themselves to see a dentist. The patient was subsequently not booked in and left the department without being seen. No record of the patients visit or the advice given to the patient was recorded. The receptionist was not a qualified health professional however they had made a clinical assessment of the patient without considering the implications in that the patient may have been experienced symptoms other than those associated with dental problems.
- Following our previous inspection in 2018, we imposed conditions on the providers registration requiring them to operate an effective process which ensured all patients were seen and treated within an appropriate timescale and that they operated a robust process by which the deteriorating patient could be assessed and treated. As a measure of increased oversight, we also asked the trust to voluntary report weekly to the Care Quality Commission against a range of metrics, including the number of patients who left the department without being seen; in part because of the poor flow across the emergency pathway and the subsequent delays patients experienced in receiving care and treatment. During this inspection, we noted that on 16 April 2019, six children were reported to have left the department without being seen. Whilst children received an initial visual assessment by the streaming nurse, there was no formalised assessment process in place for children. Therefore, it was not possible for the provider to be assured that the clinical condition of children who presented to the department was known always and therefore timely care could not be prioritised or planned.
- The trust was not reporting nationally the time it took for them to undertake an initial clinical assessment for patients arriving by ambulance. National standards state that all such patients should undergo a formal clinical assessment within fifteen minutes of arrival. We spoke with the senior leadership team who could not inform us why the reporting was not occurring nationally. However, we observed during the inspection that patients arriving by ambulance were directed to the pit-stop area during which clinical assessments were undertaken; in most of cases, such assessments took place within fifteen minutes, with ambulance crews reporting minimal delays.

Urgent and emergency services

- From 18 February to 3 March 2019 4.85% of patients arriving by ambulance had handovers delayed more than 60 minutes. This was similar to the England performance(Source: NHS England - Winter Daily SitRep).
- NHS England recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard once in the 12-month period from February 2018 to January 2019. From February 2018 to January 2019 the median time was generally longer than 90 minutes. In January 2019 the median time to treatment was 88 minutes compared to the England average of 63 minutes (Source: NHS Digital - A&E quality indicators).
- Staff used an early warning scoring system to help them to recognise the deteriorating patient. However, we noted the use of the scoring system to be inconsistent with examples whereby staff did not routinely follow trust protocols. For example, where patients scored a three on the early warning system, there was a requirement for staff to undertake further observations at intervals of one hour. During the inspection we reviewed 22 sets of notes. In two sets of notes, patients experienced delays of up to two hours and forty minutes between observations, despite in one case, the patient scoring a NEWS of five. This meant patients were at risk of deteriorating without appropriate clinical oversight.
- Whilst staff utilised a sepsis screening tool for most patients who presented to the department, the assessment and management of sepsis was not always holistic, nor was it robust. For example, in one case, an elderly patient presented with a history of a chest infection which was being treated conservatively with oral antibiotics by the patient's general practitioner. The patient's condition had worsened and so they were conveyed to hospital. The patient was tachycardia (fast heat rate) and had a productive cough. The patient scored a three on the early warning tool due to their fast hear rate. Whilst staff had completed a sepsis screen, the outcome was reported as "No" for a possible diagnosis of sepsis. This was despite the patient scoring at least three in one assessment area. Had staff followed the tool appropriately, the patient would have flagged with at least one red flag (the trust sepsis screening tool prompts patients to be considered as high risk with red flags when at least one clinical parameter on the NEWS tool scores two or more). Had staff followed the sepsis pathway, the patient should have expected to receive time critical action. The patient commenced active sepsis treatment four hours and eighteen minutes after their initial arrival into the emergency department.
- Departmental leads could not provide appropriate evidence to demonstrate that those nurses providing care to children had completed any recognised formal competency training as defined by national standards. We had previously raised this with the trust who had since reported that all band six nurses working in the department had completed European paediatric life support training (EPLS). The scope of this training however did not extend to the holistic assessment of children, including the psycho-social needs of children and the family. During our inspection, nurses allocated to care for children had not completed EPLS training and were reported to be band five nurses. Therefore, the mitigations provided by the trust were currently not sufficient to demonstrate services provided to children were sufficiently safe.

Nurse staffing

- At our previous inspections, we had reported consistent challenges regarding the employment retention and deployment of nursing staff across the emergency department. At this inspection, an interim lead nurse had been appointed to provide nursing leadership and to undertake an assessment of the emergency care pathway. The lead nurse had undertaken a staffing review of the nursing establishment at both The Princess Royal Hospital and Royal Shrewsbury Hospital emergency departments. It was noted there had been a significant and sustained shortfall in the nursing establishment. A revised nursing establishment assessment had been undertaken and approval had been provided by the trust board for the lead nurse to undertake an extensive recruitment campaign. The review, which considered best practice guidance from the emergency care intensive support team (ECIST), had been benchmarked against similar sized emergency departments to ensure the proposed new establishment was like that of other departments treating similar numbers of patients. There was recognition amongst the local leadership team that nursing recruitment would be an on-going challenge, and would likely not be resolved for a period of at least three years, due to the significant historical

shortfalls. Prior to the workforce review, there were 8.4wte nurses. Post review, this had increased to 55 whole time equivalent nurses who were to be recruited to support both emergency departments. An additional 11.2 wte band 7 senior nurse posts had been created and were to be introduced over a three year period. At the time of the inspection, 3.8wte band 7 nurses were in post with the trust reporting this had increased to 4.8 wte shortly prior to the publication of this report.

- Departmental leaders reported continued challenges in ensuring the nursing rota was sufficiently supported by competent staff. Senior leaders raised concerns over the competence of some existing band six nurses, with a lack of experience and knowledge being reported as the main areas of concern. Development and competency frameworks were being developed to help support individuals new to the role of the band six emergency department nurse.
- We had previously raised concerns over the lack of planning regarding nurse staffing for the emergency department. At this inspection, there was greater emphasis on ensuring there were sufficient nurses to support each of the clinical areas. However, the department continued to face challenges in ensuring sufficient numbers of staff were deployed at all times and with the right skills and competence. During the inspection, the interim nurse lead was required to oversee and provide nursing leadership to the corridor area as there were patients complaining of pain, poor experience and a lack of communication as to what was occurring with their care and treatment.

Medical staffing

- The trust could provide consultant presence in the emergency department seven days a week. However, the department could not consistently provide 16 hours of cover each day. The clinical lead aimed to ensure a consultant was present from 8am to 10pm Monday to Friday and from 8am to 4pm at weekends. A review of the staffing rota for the week of 15 April 2019 showed variability in the level of consultant presence. However, the department recognised peak periods and so ensured a consultant was present in the department until midnight on Mondays.
- Arrangements were in place for ensuring a consultant was on-call to solely cover the Royal Shrewsbury Hospital emergency department out of hours; this was an improvement when compared to our previous inspection when the on-call consultant was expected to cover both emergency departments.
- Junior doctors spoke positively about working in the emergency department. They told us the consultants were supportive and always accessible. Opportunities were present for training and education however junior doctors reported limited feedback on incidents, serious incidents and from morbidity and mortality reviews.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Access and flow

Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.

- At our previous inspection, we had reported the trust was engaged in a public consultation to seek the views of local people regarding changing the level of provision of emergency care services across Shropshire, Telford and Wrekin and Mid Wales. At that time, consideration was given to reducing the operating hours of the emergency department at The Princess Royal Hospital. At this inspection, no formal decision had been made, however the trust recognised the need for emergency services to be available across both the acute locations of Shrewsbury and Telford NHS Trust.
- At the time of our inspection the hospital was operating at a heightened state of escalation. Local leaders were not familiar with the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL 1; The local health and social care system capacity is such that organisations can maintain patient flow and are able to

meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care.

- During this inspection the department was under operational pressure. Increased attendances from both ambulance conveyances and self-presenting patients was reported to be placing the department and wider hospital under pressure. Flow through the emergency pathway was stagnated, with eighteen patients in the department with a decision to admit; ten patients were being cared for in the corridor due to the cubicles being full of patients. Some patients had been in the department for extended periods of time due to a lack of beds on the wards.
- The emergency department was congested with patients experiencing delays in all aspects of their care from initial assessment thorough to review by speciality doctors. The chief operating officer facilitated a capacity and demand situational report call across both acute sites at 4pm on the day of the inspection. The call was used to assess the status of the emergency pathway; to consider staffing challenges and to consider actions for those patients nearing their twelve-hour breach time. However, the meeting delivered very few actions; was orientated towards performance as compared to safety and quality; and ultimately, offered little in the way of effective management or resolution to the demands experienced by the emergency department.
- The hospital had been slow to introduce effective measures to help reduce occupancy and length of stay in the emergency department. There had been significant focus placed on addressing the four-hour performance target within the minor's pathway. However, a lack of effective or robust frailty pathway for example, meant those patients who required extended lengths of time in the emergency department, but who could ultimately be discharged home or to other places of safety had received little focus. Referral patterns to the ambulatory care pathway was reported to be limited, especially considering the fact the ambulatory unit was hosting inpatients at the time of the inspection, in line with the trusts escalation and bed management protocol; this reduced the capacity of ambulatory medics to undertake increased activity to help decongest the emergency pathway.
- Staff reported multiple patients presenting to the emergency department having been referred to medical or surgical specialities. Commonly referred to as "GP expected" patients, staff reported significant delays with medical speciality doctors attending the emergency department to review these patients; subsequently adding to the congestion of the department.
- From February 2018 to January 2019 the total time (median) in A&E was consistently longer but within statistically similar levels to England. In January 2019 the trust's monthly median total time in A&E for all patients was 179 minutes compared to the England average of 164 minutes. (Source: NHS Digital - A&E quality indicators).
- In January 2019, 61.3% of patients spent less than four hours in the trust's major A&E departments. This was worse than the national performance (76.1%) and much worse than the standard (95%). (Source: NHS England - A&E SitReps)
- In January 2019 55% of patients waited between 4 and 12 hours from the decision to admit until being admitted. (Source: NHS England - A&E SitReps)
- Over the 12 months from March 2018 to February 2019, 64 patients waited more than 12 hours from the decision to admit until being admitted. This was much worse than expected. 45 of these patients were in January and February 2019. (Source: NHS England - A&E Waiting times)

Are urgent and emergency services well-led?

Leadership

- The service was managed by an interim lead nurse who had been seconded from their substantive role, in part because of their operational and nursing experience of managing emergency departments. The lead nurse was supported by a clinical lead who was a substantive emergency care consultant. To complete the leadership team, a care group manager was in post whose remit was focussed around operational performance. There was a generally good understanding amongst the local leadership team of the challenges and risks associated with the delivery of the emergency care pathway. However, there lacked an ability for the local leadership team to address the multiple challenges and areas for

improvements which had previously been highlighted. Complying with regulatory imposed conditions had proved to be challenging with little evidence of change noted across a range of areas.

- In recognition of the need to enhance and support nursing leadership, four new band seven sister/charge nurse posts had been created across site. Staff told us many the new roles had been successfully been recruited too, with some internal promotions from the existing workforce. Some staff reported the concept of internal promotion within the service which had experienced sustained challenges and lacked insight, was a potential missed opportunity for the organisation to assess how it plans and delivers care. That said, the increase of band six nursing staff and the appointment of four substantive consultants had all been considered as positive by staff we spoke with during the inspection as it afforded an opportunity for people to bring new ideas to the department, as well as potentially securing the future of the emergency department at The Princess Royal Hospital.
- We had previously reported frustrations amongst the workforce regarding the fact frontline staff did not feel they were listened too by senior members of the executive team. These frustrations remained present at this inspection. Visibility of trust leadership was reported to be poor. The focus for the trust was reported to be based on operational performance as compared to the safety and quality of services being the driving force. Staff gave examples of beds only becoming available and released by wards very shortly prior to named patients exceeding the twelve-hour decision to admit target. This was a standing challenge for the emergency department team as it suggested sustainable solutions were not being considered, with reactive practices commanding how the emergency care pathway was delivered.

Vision and strategy for this service

- As previously mentioned, the service had been subject to a formal public consultation to consider the future of clinical services across the region. Local staff alluded to some anxiety about the future of clinical services across the trust but considered emergency service provision at Royal Shrewsbury Hospital to be safe. Staff reported the appointment of new consultants and middle grade doctors, as well as a new recruitment campaign for nursing staff were all seen as positive indicators.
- Whilst the department was in a state of escalation during the inspection, there was little in the way of effective strategy to decompress and safely manage the emergency care pathway. There was a consensus amongst staff in the emergency department that the emergency care pathway was the responsibility of the emergency care team. This was perhaps most noticeable at the 4pm operational meeting in which representation was noted only from the nursing and operational team. There was no clinical representation, so it was unclear how speciality doctors were helping to support the emergency department. The concept of utilising community based beds appeared reactive as compared to be a proactive process. Despite asking various leaders across the organisation, we could get no response as to the support being provided by the wider health economy, in line with OPEL standards. The chief operating officer could describe the strategies to reduce length of stay as well as being proud of the trusts delayed transfer of care rate. However, there was little insight in to the operational and clinical pathways which could be optimised to sustainably support the emergency care pathway.

Governance, risk management and quality measurement

- The service maintained a risk register which recorded known risks and rated them according to their potential impact. The risk register reflected the risks spoken about by staff in the department. The risk register further acknowledged some of the challenges inspectors identified during the inspection. Risks across the emergency care pathway had been considered and mitigating actions put in place for known issues. However, there remained risks for which mitigations were poorly thought through and implemented. Staffing and patient flow remained a focus as to the concerns and risks linked to the emergency pathway. Whilst senior executive leads could describe the wider system actions being taken, there was a lack of awareness in relation to timescales for completion of activities. Further, there lacked clarity as to who was responsible for the delivery of specific actions.

Urgent and emergency services

- The executive with responsibility for the delivery of the emergency pathway was poorly sighted on the risks associated with children and the lack of compliance against national service specifications for emergency care services for children. This meant there was extremely limited grip and the trust was unable to provide assurances as to how the standard of children's emergency services was going to be addressed in the future. Whilst staff reported concerns over the triage and streaming process, there again lacked any form of substantive plans to address those concerns, therefore generating a hiatus in the management of risk associated with the "Front door" pathway.
- Clinical governance meetings occurred monthly with good representation from the medical workforce. It was noted there was limited input from the nursing workforce and no representation from allied health professionals. Clinical governance meetings followed set agendas and included a review of incidents reported during the preceding month; infection prevention and control compliance; guidelines and patient information; safeguarding; risk register review; mortality and morbidity overview; patient experience; and patient safety case reviews. Serious incidents and an opportunity for any other business was also considered at the meeting. Senior staff were sighted on the challenges and risks associated with the department, however there remained gaps in terms of how such risks were being mitigated against.
- We were concerned over the lack of robust assurance associated with the information considered at the meetings. For example, at the March 2019 meeting, it was reported hand hygiene compliance was 100%; our observations during the inspection was that hand hygiene compliance was extremely poor with very little adherence to local and national best practice. Further, as we have discussed within the safe domain, compliance against EWS scoring protocols and the frequency of observations was not aligned to the trust policy. This was despite commentary within the March 2019 meeting minutes which stated, "Positive point - very robust now at doing repeat observations, even when overcrowded."

Culture within the service

- Staffing challenges continued to contribute to the low morale among the workforce. Working in challenging situation in which staff struggled to provide high quality care further compounded the challenges of the service. However, staff reported that whilst morale was low, it had improved since the last inspection in 2018. Staff reported positive outcomes regarding new posts being created; staff were realistic about the time it would take for new staff to take up posts however staff describe an appetite for change.
- A range of staff including doctors, nurses, support workers, administrative staff and representatives from the local NHS ambulance trust reported they could raise concerns to local the management team without fear of retribution. Staff told us they felt supported and were encouraged to be open and transparent. However, many staff reported receiving limited feedback from incidents and outcomes from morbidity and mortality reviews.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

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a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

1. The registered provider must ensure that within three days of this notice, 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.
2. The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.

The trust must also ensure

They operate an effective clinical governance process which is supported by reliable and tested information and datasets.

Ensure staff receive feedback on incidents and outcomes from morbidity and mortality reviews.

Ensure staff comply with local hand hygiene and infection control protocols.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. As a result of this inspection, we opted to utilise our enforcement powers and imposed urgent conditions of the Provider's registration. Namely, {cke_protected_1}1. The registered provider must ensure that within three days of this notice, it reviews and implements an effective system with the aim of ensuring that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. {cke_protected_2}2. The registered provider must ensure that the staff required to implement the system as set out in the previous condition are suitably qualified and competent to carry out their roles in that system, and in particular to undertake triage, to understand the system being used, to identify and to escalate clinical risks appropriately. {cke_protected_3}3. The registered provider must ensure that the system makes provision for effective monitoring of the patient's pathway through the department from arrival. {cke_protected_4}4. The registered provider must provide the Commission with a report setting out the steps it has taken to implement the system as required in conditions two to three, within five days. {cke_protected_5}5. The registered provider 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. {cke_protected_6}6. From 26 April 2019 and on the Friday of each week thereafter, the registered provider

Enforcement actions

shall report to the Care Quality Commission describing the system in place for effective management of children through the emergency care pathway. The report must also include the following:

a. The actions taken to ensure that the system is implemented and is effective.

b. Action taken to ensure the system is being audited monitored and continues to be followed.

{cke_protected_7} c. The report should include results of any monitoring data and audits undertaken that provide assurance that a process is in place for the management of children requiring emergency care and treatment.

{cke_protected_8} d. The report should include redacted information of all children who left the department without being seen; details of any follow-up and details of any harm arising through the result of the child leaving the department without being seen.

{cke_protected_9}7. The registered provider must ensure that within three days of this notice, 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.

{cke_protected_10}8. The registered provider must ensure that the systems in place across the department can account for patient acuity and the location of patients at all times.