Shrewsbury and Telford Hospital NHS Trust

The Princess Royal Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales; 90% of the area covered by the trust is rural. There are two main locations, Royal Shrewsbury Hospital in Shrewsbury and Princess Royal Hospital in Telford. The trust also provides a number of services at Ludlow, Bridgnorth and Oswestry Community Hospitals.

The Princess Royal Hospital in Telford was built in the late 1980s. It merged with the Royal Shrewsbury Hospital in 2003, when the Shrewsbury and Telford Hospital NHS Trust was formed. The Princess Royal Hospital provides a wide range of acute hospital services, including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. The hospital is also the main centre for hyper-acute/acute stroke services, inpatient head and neck surgery, and inpatient women's and children's services.

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

We rated Princess Royal Hospital as requires improvement overall.

- The trust was not achieving the Department of Health's target to admit, transfer or discharge 95% of patients within four hours of their arrival in ED.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery have been lower than the England overall performance since September 2015.
- Insufficient numbers of consultants and middle grade doctors were available.
- Nursing staff vacancies were impacting on continuity of care and an acuity tool was not used to assess staffing requirements.
- Compliance with the trust target for completion of staff appraisals was below the trust target.
- Current safety thermometer information was not displayed on the wards.
- The maternity specific safety thermometer was not being used to measure compliance with safe quality care.
- Mortuary staff decontaminated surgical instruments manually; this exposed staff to unnecessary risk and did not provide a high level of disinfection.
- Mental capacity documentation had not been completed for defined ceiling of treatment decisions when a person had been deemed as lacking capacity.
- Service-wide sharing of learning from serious incidents was not evident, not all staff could give examples or learning from incidents and there was limited learning across the maternity service. Communication of incident learning was not consistently service wide or fed down to all staff.
- The maternity service was in a transition period of change and although new senior leaders had begun to make positive changes, we had concerns as to whether this service had an embedded safety and learning culture. Governance processes were under review at the time of our inspection.

However, we also saw that:

- Openness and transparency about safety was encouraged. Incident reporting was embedded among all staff, and feedback was given. Staff were aware of their role in Duty of Candour.

Summary of findings

- In every interaction we saw between nurses, doctors and patients, the patients were treated with dignity and respect. Staff were highly motivated and passionate about the care they delivered.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Treatment was planned and delivered in line with national guidelines and best practice recommendations.
- Local and national audits of clinical outcomes were undertaken and quality improvements projects were implemented in order
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so.
- There was a clear statement of vision and values, driven by quality and safety. Leaders at every level prioritised safe, high quality, compassionate care.
- The trust had made end of life care one of its priorities in 2015/2016.

We saw several areas of outstanding practice including:

- The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life care patient.
- Staff told us that if the bereavement office arranged a viewing in the mortuary they would walk the relatives to the mortuary. If the mortuary department arranged the viewing, they would meet relatives at the main entrance and walk them to the mortuary department.

Importantly, the trust must:

- The trust must ensure ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients with four hours of their arrival in the department.
- The emergency department did not have a compliant mental health seclusion room as described in the Mental Health Act 2007 (MHA).
- The trust must ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery.
- The trust must ensure there are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients.
- Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment.
- The trust must review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times.
- The trust must ensure that all staff have an understanding of how to assess mental capacity under the Mental Capacity Act 2005 and that assessments are completed, when required.

In addition the trust should:

- The trust should ensure that up to date safety thermometer information is displayed on all wards
- The trust should ensure they are preventing, detecting and controlling the spread of infections, associated in the mortuary department by ensuring surgical instruments are decontaminated to a high level and there are arrangements in place for regular deep cleaning.
- The trust should ensure all staff received an annual appraisal.

Summary of findings

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Poor medical staffing levels meant that consultants regularly worked in excess of their contracted hours. Nurse staffing and skill mix meant that there were not sufficient numbers of trained children's nurses to ensure that one was on duty at all times. The department was consistently failing to meet the 4-hour waiting time standard. Paper records were not always completed accurately or in a timely manner. Electronic patient information boards were not used consistently by all staff. The department did not have a compliant mental health seclusion room as described in the Mental Health Act 2007 (MHA). Service level agreements for children and adolescent mental health services with external providers meant that patients did not always receive timely interventions. Uncertainty about the future of the department, led to low morale even though managers tried to support staff with information. Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment. However, patients were treated with respect and kindness by all staff in the department. Incidents were reported, analysed, and learning was shared with staff. Compliance with mandatory training was good. Care and treatment was based on patients' individual needs and followed recognised guidance and best practice. Multidisciplinary Team working was seen throughout the service. Patient outcomes were largely in line with England averages, where audits identified shortfalls we saw how action plans were created to address issues and improve performance. Local management was good, managers understood their role and how to support their staff and they felt engaged and supported.

Summary of findings

Medical care (including older people's care)

Good

We found that incidents were reported, analysed, and learning was shared with staff. We saw an electronic board system, which displayed patient information and allowed quick and easy access for all staff. We saw staff caring for patients in all areas that we inspected.

We saw staff using hand held electronic devices to record and monitor patient observations. This was linked to the early warning system which would alert staff if the patient results became concerning. However, the numbers of nurses on medical wards regularly fell below the safe minimum number established requiring agency staff to be used. Ward managers told us that they relied on bank and agency to cover shifts

There was not a consistent approach to oxygen prescribing on wards, in particular ward 6. Staff knew the requirement to prescribe it but when patient notes were checked there had been no evidence of prescribing on the adult prescription and administration record.

Staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 100%. Between September 2015 and November 2016, medical services achieved 58% in safeguarding adults at level 2 and 44% in safeguarding children at level 2.

Surgery

Requires improvement

We saw and staff told us that information was not always documented appropriately therefore it was at time unclear whether risk assessments or other processes had been followed and what the outcome of these were. There was no use of an acuity tool to ensure that staffing levels met the needs of patients.

Ward staff showed a lack of understanding about their role with assessing patient's capacity to consent. We saw that medicines and intravenous fluids were left insecurely in theatres. Some patients reported delays of up to three hours in the receipt of pain relief whilst on the wards.

The service was consistently not meeting the Referral to Treatment Time target of 90%. The 2016 Hip Fracture Audit highlighted that 61% of patients with a hip fracture received surgery on the day or day after admission. This was worse than the national standard of 85%.

Summary of findings

Staff were unaware of the trust vision and strategy and what their role in working towards this was. Staff did not feel the executive team were visible or had an understanding of the issues facing them and did not feel involved with future plans for the service. There were no ward meetings so staff did not have the opportunity to receive full updates or information about current issues.
However, staff treated patients in a caring and compassionate manner, they felt supported by their immediate line managers and that there was a positive culture at the hospital. There were effective tools and processes in place to meet patient's individual needs including learning disabilities and dementia. Systems were in place and staff were clear of the protocols for assessing patient risks and managing deteriorating patients and there was a positive incident reporting culture. Evidence based care was provided and care pathways were based on relevant and current guidance.

Maternity and gynaecology — **Requires improvement**

The maternity service was in a transition period of change and although new senior leaders had begun to make positive changes, we had concerns as to whether this service had an embedded safety and learning culture.
Communication of incident learning was not consistently service wide or fed down to all staff. Service-wide sharing of learning from serious incidents was not evident across the maternity service and not always timely. The maternity service chose not to use the maternity specific safety thermometer. Medicines management was poor in several maternity wards despite pharmacy audits raising concerns. There was poor compliance with the checking of resuscitation equipment. We observed poor handovers between both midwifery and obstetric staff; they lacked leadership, organisation and consistency.
Governance processes were under review at the time of our inspection. We saw evidence that although processes were in place, they were not fully embedded in the culture of the service.

Summary of findings

However, we saw there was a positive incident reporting culture. Staff understood the importance of reporting and learning from incidents. Serious incident investigations had improved and involved families in the process.
Staff were kind and professional and attentive to patients' needs. Patients felt informed and involved in their care.
Policies and procedures were based on up-to-date, evidence-based guidance. Risk registers were up-to-date, showed clear ownership and actions completed or in progress. Senior managers recognised areas for improvement and engaged with staff to drive improvement.

End of life care — **Requires improvement**

We were concerned about infection control measures we saw in the mortuary department. We saw that the department was not visibly clean and tidy, there was no specific audit programme in place to monitor cleanliness, there were no arrangements in place for regular deep cleaning, surgical instruments were decontaminated manually and infection prevention training was not part of mandatory training for staff. We also observed mortuary staff not following trust infection control policy. We found a range of consumable items that were out of date
Doctors had not completed mental capacity documentation for defined ceiling of treatment decisions when the doctor had deemed the person as lacking capacity.
There was only one palliative care nurse at the hospital they did not have enough time to spend with patients or to always follow up on them. Staff from the palliative care and EoLC team were not up to date with mandatory training.
Staff did not always ask end of life care patients where they wanted to be cared for in their last days. There was no specific data on how many people had died in their preferred location or how quick discharge took place in end of life care patients. Not all risks evident in EoLC were recorded on the trusts risk register.
However, staff were highly motivated and passionate in providing EoLC and there was a drive

Summary of findings

for change and improvement. Staff at all levels and from all departments understood the importance of a dignified death. There was evidence of good working relationships across all areas of EoLC.
The trust had made EoLC one of its priorities in their 2015-2016 strategy and had an end of life care steering group.
The trust had rolled out the Swan scheme across the hospital, providing resources for staff and practical measures for patients and families which included Swan boxes, bags and end of life information files for staff.
Funding for a full time consultant in palliative medicine had recently been approved. All staff had completed an appraisal within the past year.
Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life care patient.
The trust took part in the national end of life care audit. The trust had taken a number of actions in response to the audit.

The Princess Royal Hospital

Detailed findings

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

Detailed findings

Contents

Background to The Princess Royal Hospital

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

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

The trust has a relatively new executive team. The chief executive took office in 2015 whilst the chair has been in post since 2013. The director of nursing and medical director were also appointed in 2013. The chief operating officer has been at the trust since 2012, and the finance director is the longest standing member of the executive team (since 2011).

Shrewsbury and Telford Hospital NHS Trust has been inspected 12 times since its registration with the CQC in April 2010. Princess Royal Hospital was last inspected in October 2014 and was rated as "requires improvement".

Our inspection team

Our inspection team was led by:

Chair: Nigel Acheson Regional Medical Director (South), NHS England

Team leader: Debbie Widdowson, Inspection Manager, Care Quality Commission

The team of 30 included CQC inspectors and a variety of specialists: medical consultant, A&E consultant, consultant obstetrician, consultant surgeons, senior nurses, modern matrons, specialist nurses, theatre nurses, emergency nurse practitioner and senior midwives.

How we carried out this inspection

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

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

Detailed findings

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a much defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held five focus groups with a range of staff from across the hospital who worked within the service. In total, around 60 staff attended all those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out unannounced visits on 30 December 2016 and the 3 January 2017.

Facts and data about The Princess Royal Hospital

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

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

During 2015/16 the trust had 116,154 inpatient admissions, 407,108 outpatient attendances and 121,105 attendances in the emergency department.

For most of the period Q3 2015/16 to Q2 16/17, bed occupancy was greater than 90%; this was also consistently higher than the England average. The exception was in Q2 15/16, when it fell to 86.4% (England average 87%).

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

The Princess Royal Hospital emergency department has two entrances. One for patients arriving by ambulance and a second for patients and visitors who have made their own way.

Ambulance patients are taken directly to the majors area for handover to hospital staff and allocation of a bay. At busy times ambulance patients queue in the corridor with ambulance staff whilst waiting to be booked in.

Patients who make their own way to the department, book themselves in at the main reception desk in the waiting room. Where they then wait to see the triage or streaming nurse.

The department has four minors cubicles, 13 majors cubicles in two areas, eight new cubicles on one side of the nursing/medical hub and five original cubicles which staff refer to as mini-majors on the other side of the hub. There is a paediatric treatment room adjacent to the Minors area. A large resuscitation room with two adult and one paediatric bays ready for use and provision to open a fourth bay if the need arises. A plaster rooms with two bays, and a theatre for minor procedures. The theatre has a negative pressure system which enables it to be used for patients who might need to be isolated due to infectious disease, or for use in contamination incidents.

There is no separate paediatric accident and emergency department. There is a separate children's waiting room which is used after triage and is decorated and has toys appropriate for very young children. There is no view into the room from the main waiting room, however when other patients are called through to treatment areas they pass by the children's waiting room and there is clear view into and out of the room into the connecting corridor.

The paediatric treatment room in the Minors area has child friendly pictures on the walls and the paediatric resuscitation bay had child friendly pictures on the screens separating it from the adult areas.

There is access to the main hospital corridor from the back of the department and a separate staff only route, Imaging services are adjacent to the emergency department and there is direct access between the two areas.

The hospital was last inspected in October 2014 at which time urgent and emergency care services were rated as 'requires improvement' in the domains 'safe', 'effective' and 'responsive' and 'good' in the domains 'caring' and 'well led'.

From 1 June to 30 November 2016 the Princess Royal Hospital emergency department had 40,981 attendances, resulting in 8,553 admissions to the hospital. Of these, 10,378 were paediatric patients of which 1,681 were admitted.

A walk-in centre, run by a different NHS trust, was located across the car park from the emergency department (ED) entrance. The walk-in centre was open between 8am and 8pm. The two services operated in tandem providing a comprehensive range of services to the community.

Urgent and emergency services

During our inspection, we spoke with 15 patients or their families and 28 staff. We reviewed information provided by the trust and from other stakeholders.

Summary of findings

Poor medical staffing levels meant that consultants regularly worked in excess of their contracted hours. Nurse staffing and skill mix meant that there were not sufficient numbers of trained children's nurses to ensure that one was on duty at all times.

The department was consistently failing to meet the 4-hour waiting time standard.

Paper records were not always completed accurately or in a timely manner. Electronic patient information boards were not used consistently by all staff. The department did not have a compliant mental health seclusion room as described in the Mental Health Act 2007 (MHA).

Service level agreements for children and adolescent mental health services with external providers meant that patients did not always receive timely interventions. Uncertainty about the future of the department, led to low morale even though managers tried to support staff with information.

Stroke patients did not always receive timely CT scans due to availability and reliability of diagnostic imaging equipment.

However, patients were treated with respect and kindness by all staff in the department. Incidents were reported, analysed, and learning was shared with staff. Compliance with mandatory training was good. Care and treatment was based on patients' individual needs and followed recognised guidance and best practice. Multidisciplinary Team working was seen throughout the service.

Patient outcomes were largely in line with England averages, where audits identified shortfalls we saw how action plans were created to address issues and improve performance.

Local management was good, managers understood their role and how to support their staff and they felt engaged and supported.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Medical staffing levels meant that consultants regularly worked in excess of their contracted hours.
- Nurse staffing and skill mix meant that there were not sufficient numbers of trained children's nurses to ensure that one was on duty at all times. This was compounded by the fact that the trust saw the Princess Royal Hospital as their centre for paediatric emergencies.
- Regular checks of resuscitation equipment and medicines refrigerators were not completed when housekeeping staff were off work.
- Paper records were not always completed accurately or in a timely manner.
- Electronic patient information boards were not used consistently by all staff, which meant patients were not always seen in priority order of need.
- The department did not have a compliant mental health room as described in the Mental Health Act 2005 (MHA). Staff mitigated the risk by ensuring that patients were never left unaccompanied.
- Findings from medicine audits were not followed up.

However:

- We found that incidents were reported, analysed, and learning was shared with staff.
- There was good understanding of duty of candour amongst staff
- Mandatory training rates were good and opportunities for nursing staff to undergo additional training were also good.
- There were effective safeguarding arrangements in place.

Incidents

- The trust used an electronic incident reporting system. Staff told us that feedback from incidents had improved in recent months following an upgrade of the system.
- Trends identified in incident reports were discussed at monthly clinical governance meetings, and cascaded to staff by email, face-to-face or on the department's notice boards.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no never events reported by the emergency department at Princess Royal Hospital in the period October 2015 to September 2016.
- In accordance with the Serious Incident Framework 2015, from October 2015 to September 2016, the emergency department reported two serious incidents (SIs) at Princess Royal. We saw that these incidents were investigated thoroughly with root cause analyses (RCA) undertaken and fed back to staff through team meetings and through the trust intranet. During the same period the department reported a total of 185 incidents. The majority of the incidents 130 were classified as no harm the remainder low or moderate harm.
- Mortality and morbidity meetings took place monthly at trust level and included review of deaths which had occurred in emergency department at both sites. Information from specialists who were overseeing the patients' treatments were reviewed to identify if procedures had been followed and if there were areas for improvement.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had a policy and guidance for staff to refer to. Staff received awareness training on the duty as part of their annual mandatory training. Staff we spoke with had an understanding of the requirements relating to duty of candour in line with their role. Staff understood the need to be open and honest with patients and staff told us that they believed they always were.
- The trust had a duty of candour policy. We saw extracts from patient notes and information provided to

patients, which demonstrated how consultants had informed patients about deviations from treatment pathways and apologised for issues such as delays caused to their treatment.

Safety Thermometer

- The NHS safety thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Safety thermometer information was displayed in the emergency department waiting room. Information for October 2016 (updated in November) was displayed; the board did not contain any date specific to the emergency department.
- Data from the Patient Safety Thermometer showed that the trust reported a total of no pressure ulcers or falls with harm, and eight catheter urinary tract infections in Urgent and Emergency Care services between September 2015 and September 2016.
- The area achieved 100% in hand hygiene audits, 93.6% for patient environment, 92.5% for cleaning audit and 100% free from urinary tract infections.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy and an infection prevention and control team. Princess Royal emergency department had two IPC link nurses who were able to provide support on current IPC standards and issues.
- Patients who required isolation were cared for in treatment rooms and in addition to their records being updated, notices were displayed on the doors to alert staff to potential IPC issues.
- The emergency department had a clean appearance.
- Hand gel dispensers and hand wash facilities were available throughout the department. We observed staff using hand gel and washing their hands before and after patient contact. We saw that staff complied with arms bare below the elbow best practice. Hand hygiene audits were completed monthly we were shown copies of audits.
- We did not see many patients making use of the hand gels. We asked some patients who we saw walk past the gel dispensers why they had not used them. Almost all said they hadn't thought about it. They had been more concerned about their injury or condition or that of a relative. One family group said, "You are just so worried you don't think to do it. They should get the receptionist to remind people. It is important we should all do it."
- Personal protective equipment in the form of aprons and gloves was available throughout the department and was used and disposed of appropriately by staff.
- We saw copies of emergency department cleaning audits. The trust identified emergency department as a high risk area and set a compliance target of 98%. From June to November 2016, actual compliance varied between 95% and 92%. This meant that the hospital was failing to meet the trust's own target. Areas where audits identified failures included dust on top of monitors in treatment rooms, dried blood stains underneath a mattress and dried urine stains on a commode.
- We saw cleaning staff working in the department when we spoke with them they told us that they had been promised additional staff for over twelve months but none had been appointed. They also described difficulties regarding the effectiveness of cleaning staff on night shifts, who didn't always complete all the areas. They told us this had been escalated to their supervisors but nothing had improved.

Environment and equipment

- We saw resuscitation equipment was readily available in the department. There was a dedicated resuscitation room where patients were cared for following procedures or on arrival when it was recognised that their condition had the potential to deteriorate. There were three adult resuscitation bays and a paediatric bay. The paediatric bay included child-friendly pictures on the wall and appropriate paediatric equipment including a paediatric resuscitation trolley.
- We saw that resuscitation trolleys were appropriately equipped. However, we saw that trolleys were not always checked daily. Trolleys were sealed and lists of expiry dates of consumables were present. Sealing the trolleys meant daily checks required only a glance to ensure seals were intact, despite this we saw that checks were not being recorded. This meant that it was possible for trolleys to have been used or tampered with and staff would not be aware until they came to need the equipment. We saw that between 1 and 15

December 2016, no record had been made of checks to the adult resuscitation trolley on five occasions, and no record of checks to the paediatric resuscitation trolley appeared for 11 occasions of a possible 15.

- Checks of resuscitation trolleys were usually completed by the 'housekeeper'. The housekeeper had received training as an operating department practitioner (ODP) and also worked as an ambulance first responder for another trust. The training for these roles had provided the skills and experience to enable them to carry out the safety checks; however when the housekeeper was off there was no reliable system in place to ensure that other staff took over the responsibility.
- We were shown a room where deceased patients were sometimes placed whilst awaiting transfer to the mortuary. We were told the room was occasionally used to allow relatives to pay their respects. However, the room also doubled as a major incident equipment store. The industrial equipment was separated from the viewing area by a cubicle curtain. The presence of the equipment could be considered disrespectful to the deceased. The housekeeper told us the trust was proposing to purchase a shed and move the equipment, although they did not know when this would take place.
- The department did not have a compliant mental health room as described in the Mental Health Act 2005 (MHA) Codes of Practice 2015. We were shown a room with a table and chairs, which staff described as the "mental health interview room". To meet the standard, rooms are required to have two exits, have furniture fixed to the floor, have no ligature points, windows should be secure and obscured to protect privacy. The interview room did not match any of these features. We were assured that patients were never left alone in the room.
- Staff we spoke with told us that they did not have problems with availability of equipment. We saw that portable electrical equipment had been safety tested and carried stickers showing when further tests were due.
- Security of the department was poor. Open access was available from the reception area into the minors, majors and resuscitation areas. We also saw that the security door between the main hospital corridor and the department was for the most part propped open. During our two day inspection and during our unannounced inspection the corridor door was continually open.
- When we entered the department we identified ourselves to staff and were asked for identification, however we saw other people walking through the department unchallenged. We did witness one member of staff challenging people in the department on two occasions, asking why they were present and giving appropriate advice on other routes. We did not see any other members of staff challenging people. We saw that supplies of medical gasses, trolleys and monitoring equipment were all readily available.

Medicines

- Audits of controlled drugs, which require special storage and records, and resuscitation trolleys, were completed four times per year. The trust provided us with the last three audits for each of these areas.
- Safe and secure handling of medicines audits were completed annually. We reviewed the audits from 27 May 2014, 4 November 2015 and 16 December 2016.
- We saw that audits had identified issues and had resulted in action plans being drawn up; however we found the actions often failed to rectify problems. For example, resuscitation area audits on 31 March, 30 June and 8 November 2016 all identified a lack of a stock list. The same issue appeared in controlled drugs audits on 8 March and 30 June 2016.
- The audits showed other areas where issues had been identified at one audit and continued to be a problem at the next audit. These included: missing signatures from entries in registers, crossings out in registers, balance transfer details not being shown when starting new registers, incomplete recording of 'amount used' and 'amount wasted' when using part of an open vial of controlled drugs.
- During our inspection we found other discrepancies with the storage and handling of medicines which the trust had identified during earlier audits yet continued to be issues in following audits. For example, we saw missed temperature checks of refrigerators used for the storage of temperature sensitive medicines in the resuscitation room where two checks had not been recorded between 1 and 15 December 2016.
- Small oxygen cylinders in storage areas were not secured to prevent them falling. We saw one large and three small cylinders all standing unsupported on the

floor, adjacent to securely stored cylinders outside the plaster room. This meant that cylinders were not stored in accordance with the British Compressed Gas Association (BCGA) guidance CP44.
- Fluid stores were not locked. The fluid store was accessed through the resuscitation room and we saw that on occasions both the resuscitation room door and store room door were open with no staff present.
- In common with the resuscitation equipment, regular checks were completed by the housekeeper; however there was no reliable system to ensure the checks were completed when the housekeeper was not at work.
- We checked the contents of medicine cabinets and refrigerators and examined a random sample of medicines. We found that cabinets were secure. The medicines were all within their safe use by dates.

Records

- We checked a number of records regarding the general running of the service and maintenance of equipment we found these records were complete and stored appropriately.
- We checked eight sets of patient records; we did this as we wanted to ensure that what patients and staff had told us was reflected in the records. Records were made up of a series of loose notes and care pathways folders. It was not always easy to find information within the notes and some handwriting was difficult to read.
- Patient notes were not always completed in a timely manner. We saw that one patient who did not require admission to the hospital and was waiting for an assessment of her on going care needs in the community had been left in a curtained cubicle for over eight hours without any nursing comfort notes being completed.
- One set of patient notes had incorrect address details. The ambulance paperwork showed that the patient resided at home with their spouse. On the forms completed by the nursing staff the person was listed as living alone in a care home. This was pointed out to the nurse coordinator who amended the records.
- One set of patient records contained three loose sheets of information relating to three other patients. We removed these and handed them to the nursing coordinator to enable them to be placed with the correct records.
- The service did not use electronic patient records and all notes were paper-based. Wall racks were distributed around the department with cubicle or treatment room numbers. Notes for the patient currently occupying the cubicle or treatment room were placed in the corresponding rack. We noted on a number of occasions nurses or doctors looking at the racks, turning to colleagues and asking 'Has anyone got the notes for…" and adding the relevant cubicle number. This was because the notes were being updated in the hub or on one of the nurse bases.
- We saw the department had an electronic white board which contained details of all the patients in the department and could also be used to view all the patients in the emergency department at the Royal Shrewsbury Hospital. The system was very comprehensive and had the ability to include nursing updates in relation to early warning scores and the current status of patients. The system also had provision for the allocated doctor to update the system with their details and any notes they wished to add. However, we saw that doctors did not engage with the system even though we witnessed them being asked to do so during the medical handover.
- We were told that some consultants in the department considered the system over complicated and would not engage themselves or encourage their junior doctors to use the system. The volume of patients through the department was such that nursing coordinators could not always recall which doctor was attending which patient and if they wished to update the doctor or ask for further tests they had to find the paper records to identify the doctor concerned, locate the doctor and discuss the issues. If the electronic system was used the information could be added to the system as a note for the doctor who could respond accordingly.

Safeguarding

- In September 2016, the CQC completed a review of health services for looked-after children and safeguarding in Telford and Wrekin. The review included provision within the emergency department at the Princess Royal Hospital. As a result of the review a number of recommendations were made; nine of which directly affected the emergency department services at the Princess Royal Hospital.
- The inspection report concluded that the emergency department had a well-established system for identifying children who might benefit from early help or additional support from universal services.

- We asked the trust for an update on the recommendations and they provided an action plan based on the recommendations. We saw that immediate action had been taken in respect of some of the recommendations, with information and guidance provided to staff and appropriate recording and reporting systems put in place.
- A recommendation to strengthen the resources of the safeguarding team to ensure that the named nurse had sufficient capacity to fully carry out quality monitoring had resulted in discussion with the Associate Director of Patient Safety, and recommendation that a business case be developed for two specialist nurses and administrative support to be recruited.
- The trust had a safeguarding policy with advice and guidance for staff. A safeguarding lead was available and staff we spoke with understood the different types of abuse how to recognise them and how to support victims. Assessment sheets included prompts to staff to consider abuse including domestic abuse and female genital mutilation (FGM).
- We saw records, which showed that all nursing staff in the emergency department were trained to level 2 in adult and children's safeguarding. Three senior sisters and the matron were qualified to level 3 and fulfilled the paediatric nurse role when required. All nursing and healthcare workers in the department undertook a paediatric training day during which they received child safety awareness training.

Mandatory training

- We saw records which showed that 90% of nursing staff had completed all their mandatory training subjects against a trust target of 100%.
- In addition, 96% of the nursing staff had completed intermediate life support training and 97% had completed paediatric intermediate life support training. The senior staff nurses and sisters had also completed European Paediatric Life Support courses.
- Conflict resolution and equality and diversity training stood at 98% and 99% respectively.
- In addition to mandatory training nurses were able to complete additional training to increase their knowledge and skills. This included: diabetic training, ALERT course (a multi-professional course to train staff in recognising patient deterioration and act appropriately in treating the acutely unwell), fundamentals of care, stabilising the critically ill child, sepsis and management of the acutely ill adult and assessment of the acutely ill adult university module.

Assessing and responding to patient risk

- Ambulance patients were brought directly into the department through a dedicated entrance. Ambulance staff approached the nurse coordinator and handed over the patient either directly or to an allocated nurse. We witnessed several such handovers and saw that comprehensive health information was provided which enabled hospital staff to start the assessment process.
- Where patients were on route with life threatening conditions, ambulance staff telephoned the department with initial details and an expected arrival time. We saw this system worked effectively when a paediatric case was communicated to the nurse coordinator. Additional specialist staff were called to the department and met the patient on arrival in the resuscitation room.
- Patients who self-presented were booked into the department by non-clinical staff who took details of the person's health issues. Patients then waited in the waiting room to be seen in turn by the "streaming" nurse. The department used a combination of triage and streaming of patients. Streaming involved assessment of the patient's needs and then referring them back to GP services, on to Minors or Majors section of the emergency department or in some cases direct referral to specialist departments in the hospital. Triage involved a complex decision making process designed to manage clinical risk, and identify or rule out life/limb threatening conditions to ensure patient safety. The streaming nurse was supported by a healthcare worker, who was trained to take blood samples and other observations. This meant that by the time patients saw a doctor, information was available to assist in their diagnosis. Patients were streamed away from the hospital to alternative appropriate services, to minors for less serious issues and majors for more serious. If required, patients could be streamed direct to the resuscitation room for closer monitoring.
- We saw that risk assessments were completed for individual patients; these included early warning scores, falls assessments and malnutrition universal screening tool (MUST) scores.
- All majors and resuscitation bays had electronic monitoring systems which alarmed to alert staff if vital

signs fell outside expected parameters. Nursing staff monitored and recorded early warning scores in line with clinical care pathways, using the National Early Warning Score (NEWS) system. NEWS is a guide used by medical services to quickly determine the degree of illness of a patient.

- Deteriorating patients should be escalated to senior nursing staff or the attending doctor. However, we were told that when the department became busy, there had been incidents when early warning scores had not been communicated in a timely manner. One consultant described finding a patient who's NEWS score had increased to 9 but had not resulted in an escalation.
- Nursing staff including senior members of the team told us the electronic monitoring system was unreliable and had limited functionality within their department. When using the system in the emergency department nurses had to input information into the device and because it did not connect electronically to patient records they then had to copy the information across to the paper records, they also had to manually input the information into the electronic white board. Nurses told us they found it easier to update the paper record and white board and not use the electronic system. One feature of the electronic system was that monitoring times could be set dependent on a patient's needs and the system alarmed to remind staff when a particular patient's vital signs needed repeating. With the chaotic recording system and paper record filing system there was a risk that patients would not receive timely checks when the department was busy.
- The Royal College of Emergency Medicine (RCEM) recommend that the time patients should wait from time of arrival to receiving treatment is no more than one hour. RCEM data is recorded at trust level. The trust met the standard for seven months over the 12 month period between August 2015 and July 2016.
- Trust wide performance against this standard showed a trend of decline. In July 2016, the median time to treatment was 66 minutes compared to the England average of 62 minutes. Throughout this period, the trust's own figures closely followed the England average, and both the trust and England average figures have exceeded the standard for five out of the months six from February to July 2016. In June and July 2016, the trust's median time appeared to be rising at a higher rate than the England average.
- The median time from arrival to initial assessment was higher than the England median throughout the 12 month period. In July 2016 the median time to initial assessment was 11 minutes compared to the England average of seven minutes. The trust's highest recorded median time was fifteen minutes, in March 2016; otherwise it varied between 11 and 13 minutes during 2016.
- From November 2015 to October 2016, the Princess Royal Hospital reported an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In November 2015 40% of ambulance journeys had turnaround times over 30 minutes; in October 2016 the figure was 57%.

Nursing staffing

- There was no nationally recognised tool to assess the number of nursing staff required in emergency departments. Daily staffing consisted of nine qualified nurses and two healthcare assistants during the day, and six qualified nurses on nights. These levels were based on historic demand and predicted capacity. Shifts were staggered with some staff starting later to enable cover for breaks and to spread the workload. Total nursing establishment was 48 qualified staff and six healthcare assistants. Nursing and healthcare staff at the hospital worked 12-hour shifts.
- Staffing levels in the department had been static since at least 2014; the exception being that an additional qualified nurse was brought in to assist with winter pressures during the winter of 2015. This temporary post ended in spring 2016. At the time of our inspection, we were told that no such provision had been made for the current winter of 2016/2017. The staggering of start times for nursing staff meant that if patients were admitted who required to be nursed in the resuscitation area due to their condition between 7am and 11am, nursing staff were taken from the minor injuries area of the emergency department. Resuscitation patients should ideally be nursed on a one to one basis. We were told that it was common for the resuscitation area nurse to be left with two or even three patients until the additional staff arrived, although we did not see this occur during the inspection.
- Agency nursing staff were used to fill planned vacancies where emergency department bank staff were unavailable. The department had a standing block booking of three agency nurses to cover night shifts.

- Senior nursing staff and some consultants told us they thought nursing staff levels were barely adequate and at busy times were dangerous. In the later part of 2014, the trust responded to issues of patients waiting with ambulance staff in corridors by increasing the number of available cubicles in the majors section of the department. The capacity increased from ten to eighteen cubicles. We were told that staffing levels remained the same based on the premise that the same number of patients were going through the department therefore the same number of staff were required to nurse them. However, calculations had not taken into account the care afforded by ambulance staff whilst waiting to hand over patients. For example if ten patients per day were delayed an hour, the trust would have had two paramedics for each patient providing care or oversight during that period, in simple terms this would amount to 20 hours of care a day which was not being provided by the emergency department team. Once the new cubicles were taken into use ambulance handovers were completed largely within the 15 minute target time, but nursing staff now had responsibility for all the patients.
- Nurses coming on duty were allocated to specific areas of the department. Following this each nurse or healthcare assistant went to meet with their night shift counterpart and went through a detailed individual handover of each patient in that area. In addition the nurse coordinators, usually senior sisters, met to complete the department handover. We observed the different handovers and saw that patient status, risks, and general wellbeing were discussed.
- Even though the Princess Royal Hospital was the trust's paediatric centre and all non-trauma paediatric cases were meant to be seen there, the department had only four trained children's nurses which meant they were unable to ensure that at least one children's nurse was on duty at all times, in accordance with Royal College of Paediatrics and Child Health (RCPCH) guidance.
- In September 2016, the CQC completed a review of health services for looked-after children and safeguarding in Telford and Wrekin. The report had recommended that the trust ensure sufficient numbers of qualified children's nurses be on duty, the trust action plan identified that whilst the department tried to rota one paediatric trained nurse for each shift, due to vacancies and skill mix this wasn't always possible, and that the next available children's nurse qualification course was in 2018.

Medical staffing

- The Royal College of Emergency Medicine suggests that 16 consultants were needed to run a safe effective emergency department. The Shrewsbury and Telford Hospital NHS Trust had six substantive emergency department consultants shared between the two emergency departments. Two consultants worked only at the Princess Royal Hospital whilst the others were rostered between the two sites.
- We asked the trust for detailed medical staffing numbers on four dates in November 2016. During the 24-hour period of Monday 7 November, there had been a total of seven Senior House Officers (SHO's) of which two had been locum doctors; four Middle Grade doctors (MG) which had included three locums and four consultants of which one had been a locum. Overnight cover had been provided by an on call consultant.

During the 24-hour period of Sunday 13 November 2016, there had been only five SHO's and three MG's, with 24-hour call out cover from a consultant.

During the 24-hour of Wednesday 16 November 2016, there had been four SHO's, five MG's of which two were locums and four consultants of which two were locums. Overnight cover was provided by an on call middle grade doctor.

On Friday 25 November, there were six SHO's (one being a locum), six MG's (two being locums) and four consultants (two being locums) Overnight cover was provided by an on call medical grade doctor.

- In June 2016, the proportions of consultant staff and junior doctors reported to be working at the trust were lower than the England average with only 20% consultants.
- We were told that the trust struggled to recruit doctors to the emergency department. A number of factors were quoted including, uncertainty about future changes, current practice of working across two sites and the availability of higher profile posts in neighbouring larger trusts.
- As a result of these recruitment difficulties, night cover at Princess Royal Hospital emergency department had

been provided for over twelve months by a locum doctor service. Staff told us that locum cover was very good, regular doctors provided the cover which meant there was continuity and they were familiar with the location processes and staff.

- Consultants were rostered to work between 8am and 8pm after which a call-out rota applied. Due to contractual agreements with individual consultants, not all consultants at the trust covered both emergency departments. We were told this reduced flexibility in the department and made rotas difficult to maintain.
- One consultant we spoke with told us that although their shifts were due to finish at 8pm, it was not unusual for consultants still to be in the department at 11pm just to cope with the demand.

Major incident awareness and training

- All staff working in the emergency department received major incident training. Incident cards were available for staff or supervisors which enabled staff to understand their role in any major incident scenario.
- Business continuity plans were in place. These included standard operating procedures in the event of services not being available. We saw evidence of this in relation to the availability of computerised tomography (CT) for stroke patients who arrived in the emergency department.
- Chemical, biological, radiological and nuclear (CBRN) and hazardous material (HAZMAT) decontamination equipment and protective suits were available. We reviewed the storage of these and saw documentation which confirmed they were regularly checked and available for use.
- The trust had security officers who patrolled the hospital and grounds. Security officers were used to support staff when patients were potentially aggressive, this included the emergency department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Treatment pathways were based on recognised guidance and best practice.
- Pain management was based on the Faculty of Pain Medicine's Core Standards and patients told us that staff had responded to requests for pain relief.
- Patient outcomes were largely in line with England averages, where audits identified shortfalls we saw how action plans were created to address issues and improve performance.
- Multidisciplinary Team (MDT) working was seen throughout the service.

However:

- Service level agreements for children and adolescent mental health services (CAMHS) with external providers meant that patients did not always receive timely interventions due to limited time frames for referrals.

Evidence-based care and treatment

- We saw care pathway documents which were based on national Royal College clinical guidance and best practice. These included the 'sepsis six' pathway which assisted staff to identify and provide appropriate treatment for patients presenting with sepsis symptoms. We noted that the computer 'wallpaper' screens in the emergency department had the 'sepsis six' flow chart displayed as a constant reminder to staff to consider the condition. We also saw neck of femur and stroke pathways which were based on national guidance and best practice.
- Procedures and policies were based on the 'Clinical Standards for Emergency Departments' guidelines; although the lack of computerised patient records meant that patients were not always prioritised according to acuity and need.
- The Princess Royal Hospital was the trust's stroke unit. Clinical trials have shown that stroke patients receive better outcomes when treated and cared for in dedicated stroke units. We saw that standard operating procedures were in place throughout the trust and with external ambulance trusts to ensure that patients who had or who were suspected of having had a stroke were directed to the Princess Royal Hospital for appropriate care. When stroke patients arrived at ED, staff liaised with the stroke unit. When patients were stabilised they were transferred to the unit for on-going treatment. We saw emergency department staffing handing a patient over to a member of the stroke nursing team. We saw

how relevant information about the patient's condition, tests which had been completed and outstanding test results were all discussed such that the receiving staff had a full knowledge of the patient concerned and their status.
- Pathways for paediatric patients were based on the Royal College of Paediatric and Child Health guidance and included the ability to stream patients direct to the paediatric assessment unit without their needing to see an emergency department doctor first.
- All children under the age of six months were seen by a qualified paediatrician.

Pain relief

- Pain management in the trust was based on the Faculty of Pain Medicine's 'Core Standards for Pain Management (2015)', which had been incorporated into trust policy. Pain scores were recorded when patients were first assessed by nursing staff during the streaming/triage process or at handover from ambulance staff. In cases where it was appropriate to give analgesia pain scores were repeated if patients remained in the department for any length of time.
- In the CQC emergency department Survey 2014 which measures trust wide performance, the trust scored 4.93 out of 10 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.
- The trust scored 7.49 out of 10 in the same survey for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as than other trusts.
- Patients we spoke with told us that staff had responded quickly to their requests for pain relief.

Nutrition and hydration

- In the CQC emergency department Survey 2014 which measures trust wide performance, the trust scored 6.76 out of 10 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as than other trusts.
- Patients told us that they had been offered refreshments at appropriate periods.
- We saw patients being offered food and drinks at appropriate times of the day.

Patient outcomes

- The trust were not outliers for any clinical procedures within the emergency department. This meant that clinical outcomes were within NHS England expectations.
- In the 2013 Royal College of Emergency Medicine (RCEM) audit for consultant sign-off, the Princess Royal Hospital was in the upper quartile compared to other trusts for two of the four measures and was between the upper and lower quartiles quartile for two of the four measures.
- The measures for which the hospital performed in the upper quartile were; consultant or associate specialist saw the patient (21%), ST4 or more senior doctor saw the patient (61%) and ST4 refers to doctors in their fourth year of specialist training.
- Following this audit, the trust completed a re-audit, and introduced additional training for junior doctors on their induction regarding guidance on consultant sign off in emergency departments. The new training was introduced in February 2015 and following a 12-month trial was signed off in February 2016 as a recognised part of the induction training. This showed a willingness to improve services even when they were already performing well.
- In January 2015, the RCEM published their National Report – Asthma in Children Clinical Audit 2013/2014. The Princess Royal Hospital was in the upper quartile compared to other hospitals for four of the ten measures, and was in the lower quartile for one of the ten measures
- The measures for which the hospital performed in the upper quartile were; respiratory rate (76%), pulse (76%), Glasgow Coma Score (74%) and Beta 2 agonist given by spacer or nebuliser within 10 minutes of arrival (24%). Beta 2 agonist are used to relieve symptoms in asthma sufferers. The measure for which the hospital performed in the lower quartile was systolic blood pressure (4%).
- In the 2013/14 RCEM audit for paracetamol overdose, the Princess Royal Hospital was in the upper quartile compared to other hospitals for two of the four measures and was in the between the upper and lower quartiles for the other two measures. The measures for which the hospital performed in the upper quartile were; proportion of patients that received

N-acetylcysteine within one hour of arrival (33%) and staggered overdoses receiving N-acetylcysteine within one hour of arrival (4%). This is a treatment used to counteract paracetamol poisoning.

- In the 2013/14 RCEM audit for severe sepsis and septic shock, The Princess Royal Hospital was in the upper quartile compared to other hospitals for one of the 12 measures and was in the lower quartile for four of the 12 measures. The measure for which the hospital performed in the upper quartile was First IV crystalloid fluid bolus given in emergency department within one hour (53%).
- The measures for which the hospital performed in the lower quartile were; vital signs fully recorded in emergency department emergency department notes (67%), vital signs fully recorded in emergency department notes within 15 minutes of arrival (42%), evidence in notes that blood cultures were obtained in ED (47%) and antibiotics administered in emergency department (84%).
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the Princess Royal Hospital was in the upper quartile compared to other hospitals for two of the six measures and was in the between the upper and lower quartiles for four of the six measures. The hospital met the fundamental standard of having an early warning score documented.
- In the 2014/15 RCEM audit for initial management of the fitting child, the Princess Royal Hospital was in the lower quartile compared to other hospitals for one of the five measures and was in between the upper and lower quartiles for the remaining four measures. The hospital met the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival. The measure for which the hospital performed in the lower quartile was Presumed aetiology (cause or causes of a disease) recorded for all audited patients (98%).
- In the 2014/15 RCEM audit for mental health in the ED, the Princess Royal Hospital was in the upper quartile compared to other hospitals for three of the eight measures and was in the lower quartile for two of the six measures. Of the two fundamental standards included in the audit, the hospital did not meet the fundamental standard of having a documented risk assessment taken. The hospital did meet the fundamental standard of dedicated assessment room for mental health patients, although the room was not.
- The measures for which the hospital performed in the upper quartile were; risk assessment taken and recorded in the patient's clinical record (88%), mental state examination taken and recorded (90%) and patient assessed by a mental health practitioner from organisation's specified acute psychiatric service (90%).
- The measures for which the hospital performed in the lower quartile were; details of any referral or follow-up arrangements documented (58%) and assessed by mental health professional within one hour (0%).
- Other audits which the trust engaged with included:
  - The UK Trauma Audit and Research Network (TARN) - Severe Trauma 2015. Trauma deaths were reviewed separately by an emergency department consultant.
  - College of Emergency Medicine: fitting children 2014/15. The symptoms are now included in scenario teaching in the trust.
  - College of Emergency Medicine: mental health in the emergency department 2014/15 was completed at the Princess Royal Hospital and resulted in the pro-forma used by staff being amended. The new form has been trialled twice and is being further developed before being adopted trust wide.
  - RAID (Rapid Assessment, Interface, Discharge Team) notes are now included in emergency department notes. As a result of local audit activity.
  - College of Emergency Medicine: Vital signs in children & Non Accidental Injury (NAI) checklist 2015 conducted at the Princess Royal Hospital.
  - Young People's and Young Adults Mental Health National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
  - College of Emergency Medicine: Procedural Sedation 2015 conducted at the Princess Royal Hospital. This led to the creation of a new sedation pro-forma implemented trust wide in February 2016.
- From August 2015 to July 2016, the trust's unplanned re-attendance rate to emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average. In the latest period, trust performance was 5.3 % compared to an England average of 7.7 %. Throughout this period, the trust's rate reached its

highest point between February 2016 and June 2016, during which it fluctuated between 5.8% and 6.2%, before falling again July 2016. Outside of this period it was closer to the national standard, though did not fall below 5% at any point. In contrast, the England average rate varied between 7.3% and 7.8% throughout this period.

Competent staff

- The 2016/17 appraisal rate for nursing staff stood at 80%. Staff who had not yet received an appraisal had identified dates for them to be completed during the current year, with the exception of two staff on maternity leave.
- Medical staff received clinical supervision and undertook weekly training sessions with consultants. The training and schedule were described to us by one of the consultants who was showing us the area used for training.
- We saw that staff had the qualifications and skills required to work in the department. Senior nursing staff explained that they would only accept experienced nurses into the department so that they were able to cope with the demands on them. They told us that newly qualified nurses, whilst keen and eager often required additional support from their peers. They said the department was often too busy to ensure sufficient support could be provided. Senior nursing staff had informal arrangements with one of the hospital wards, which enabled new staff to work on the ward to gain some experience before having to cope with the pressures of ED.
- The matron and senior sisters all had clinical work days, this enabled them to retain their skills and understand the pressures of their workforce. They described how they used both protected time and their clinical work time to assess nurses' practice and provide advice and guidance where appropriate.
- Staff were encouraged to revalidate their professional registrations. The revalidation process required staff to evidence their work and show competence which helped maintain standards and ensured they were up to date with current best practice and guidance.
- The hospital had two Emergency Nurse Practitioners (ENPs). ENPs are registered nurses who have acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice. We spoke with one ANP who told us that they rarely had the opportunity to utilise their additional skills as they were "More use to the department as general nurses due to the high demand".

Multidisciplinary working

- We saw how different specialities worked together in emergency department to support patients. Nursing staff and doctors worked closely together with therapists. We saw how the frail and elderly assessment team liaised with nurses and doctors both before and after assessments had been carried out.
- Doctors all worked from a central hub in the department, this enabled them to discuss patients with colleagues and nursing staff.
- The trust operated a number of specialist services at each of its sites, for example the stroke unit was based at Telford, whilst Shrewsbury was a trauma unit. The trust had developed service level agreements with ambulance trusts to ensure that patients who required these specialities were conveyed to the appropriate hospital.
- We saw how other areas of the hospital supported the emergency department functions. An example being where advance notification had been given of a paediatric emergency case on route to the hospital. We saw how, within minutes of the call going out, a paediatrician and other specialists and support staff had made their way to the emergency department resuscitation room in readiness for the patient's arrival. We also observed the handover of a suspected stroke patient from emergency department staff to a member of the stroke team.
- The trust were reliant on an external trust to provide children and adolescent mental health services (CAMHS). The service level agreement with the other trust meant that patients who fell into this group did not always receive timely interventions from suitably qualified staff. We saw one young person in the emergency department who required CAMHS and the referral time for handing over to the external service had passed and even though staff were on site they initially declined to see the patient. We escalated this and arrangements were made for the patient to be seen.

Seven-day services

- Princess Royal Hospital emergency department was open all day everyday throughout the year.

- However, a number of support services were only available during core weekday hours; these included the frail and elderly assessment team. The team worked to speed up discharge of patients who had received treatment, but due to their condition required additional support from community based services in order to cope when they returned home.
- X-ray services were also limited but there was a call out system for emergency imaging.
- The hospital was the stroke centre for the trust, and had a twenty-four hours a day, seven days a week computerised tomography (CT) scanning service which was available for patients who were suspected of having suffered a stroke who arrived through the emergency department. We did find issues with the availability of this service which are reported in the responsive section of this report.

Access to information

- Nursing and medical staff had access to policies, procedures and standard operating procedures through the computer terminals throughout the department. We saw that there were sufficient terminals to enable staff to access systems when they needed to.
- Patient records were paper based and we saw that this caused some problems when staff were looking for records which other staff had removed or replaced in the wrong area. We also saw how some loose notes were filed in the wrong records; although this appeared to have occurred as a result of a member of staff gathering up a number of loose notes from the nurse station and placing them in one set of notes. Three individual notes related to three separate patients. The notes related to contact details or other non-clinical matters.
- Staff had access to the trust intranet and all had personal email accounts. Information affecting the trust was posted on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to describe how they ensured patients had capacity to consent to procedures provided. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support them.
- We saw records which showed that staff received awareness training as part of their annual mandatory training 90% of nursing staff had completed all their mandatory subjects. Patient records contained sections on consent and, where appropriate, these had been signed.
- Emergency situations required that staff often had to make decisions on behalf of patients who were unconscious or unable to make reasoned decisions or provide informed consent because of their injuries or the pain they were in. Staff described how in such cases treatment was given which was believed to be in the best interest of the patient. We were assured by senior nursing staff that in such cases patients or their relatives were informed of the actions taken and reasons for them at the earliest opportunity, and that all such actions were recorded in patient notes.
- However, during our inspection we saw one patient in a cubicle whose trolley bed had been raised at the foot end to prevent them getting off. The patient had neurological problems which meant they were prone to wander and prone to falls. We looked at the patients notes. There was no mention of discussing the restriction of movement with the patient; and no record of the reasons or justification for it. This was brought to the attention of the nurse in charge who asked one of the attending doctors to update the records.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Patients were treated with respect and kindness by all staff in the department.
- We observed staff taking time to explain to patients and their families what they were doing, what tests they were proposing to do and ensuring that patients understood.
- Friends and family tests scores were better than the England average.

However:

- The department did not have clear plans to ensure that patients who did not require admission to hospital but who could not be discharged, continued to receive appropriate support in terms.

Compassionate care

- We observed how staff in the department interacted with patients and with visitors. We saw and heard how staff greeted people by introducing themselves. Interactions were polite and courteous.
- We saw how doctors and nurses moderated their approach to patients to match the situation. Initial consultations were professional and friendly while ensuring that symptoms and history were properly recorded and understood. Subsequent meetings were less formal, particularly with nursing staff who built up a rapport with their patients and engaged in light-hearted chat whilst providing care or undertaking tests.
- We saw that screen curtains were drawn around patient beds or across cubicles when care, treatment or consultations took place. Because of the open environment in the department it was possible to overhear conversations in cubicles. We did note that staff lowered their voices when talking about sensitive issues which helped to maintain privacy.
- When the department became busier we saw that ambulance patients had to queue in the corridor with ambulance staff attending them until they could be booked into a bay. Similarly, patients who were waiting to be taken to or returned from X-ray were queuing in the corridor, often with family members standing with them. This meant that patient's dignity was not always protected as they were on view to other patients and relatives.
- The 2014 inpatient survey asked patients "Were you given enough privacy when being examined or treated in the emergency department?" The trust scored 8.9 out of ten.
- The 2014 emergency department survey asked about patient satisfaction. Patients' responses were predominately very good. When asked about how staff dealt with patients' anxiety the emergency department overall (Shrewsbury and Telford sites) scored 7.3 out of ten. Explaining the need for tests scored 8.6. Receiving test results 8.1. In addition, explanation of test results scored 8.9. Overall satisfaction in the department scored 8.1.
- From September 2015 to September 2016, Friends and Family survey results for both of the emergency departments in the trust as a whole varied between 90% and 95% of patients who would recommend the services to family or friends. This was consistently better than the average response for all England emergency departments, which varied between 83% and 88% during the same period.
- The urgent and emergency care Friends and Family Test (Shrewsbury and Telford combined) was consistently above the England average from September 2015 to August 2016. In the latest period, August 2016 trust performance was 93.4% compared to an England average of 86.9%.
- Friends and family responses displayed on the AMU quality board in the emergency department waiting room showed that there had been 929 responses during 2016, of which 96.5% would recommend the service.

Understanding and involvement of patients and those close to them

- The 2014 inpatient survey asked patients if they had received sufficient information about their condition whilst in emergency department at the trust. The trust scored 8 out of ten for this area.
- When we spoke with patients and members of their families they all told us that nursing staff and doctors had been very thorough, explaining the tests they were proposing to do and why they were necessary.
- A number of patients we spoke with were frustrated that staff could not tell them how long tests would take or how long they might need to be in the department.

Emotional support

- Nursing staff explained how senior nursing staff or more usually doctors would take responsibility for speaking with patients or family members when bad news had to be given.
- An interview room was used where people could speak privately with staff or sit and gather their thoughts.
- A chaplaincy service was operated by the trust and there was a multi faith prayer room in the hospital for staff and patients to use.

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

Urgent and emergency services

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- The hospital was consistently failing to meet the 95% target of patients who attend emergency departments being admitted, transferred or discharged within four hours. Performance was 81% against an England average of 89%.
- The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. The trust average was 21%, against an England average of 8%.
- Patient flow through the department was slow, large numbers of patients were not seen within four hours.
- The department's capacity could not respond to patient needs, the system for prioritising patients was not effective.
- Systems were in place to identify patients who required additional support, such as those who were at risk of falling. However staff were often too busy to give these patients the additional support they required.
- Translation systems were ad-hoc, some staff told us they had given up trying to use telephone translation services as they had been asked for a password and they did not have one.
- Diagnostic imaging for patients suspected of having suffered a stroke were not always available in a timely manner.
- Facilities in the department did not meet the Royal College of Paediatricians standards

However:

- Care and treatment were based on patients' individual needs. Care plans included preferences and identified vulnerabilities.
- Appropriate risk assessments were completed and reviewed.
- Visual aids were used to enable staff to recognise patients with additional needs. These included the 'Butterfly' scheme to identify dementia or memory problems and coloured arm bands for patients at risk of falls.
- Complaints were recorded and information was shared with staff.

Service planning and delivery to meet the needs of local people

- Services were planned to make appropriate use of the facilities and staff available at the location. The department was working to its capacity and, at busy times, beyond its capacity.
- Consultants and managers told us the emergency department at Princess Royal Hospital could not meet the demands of a growing population created by expanding urbanisation. Increases of both very young and elderly citizens, some of whom had multiple complex needs, had outstripped the capacity of the department. National demographic information indicated that from 1 January 2000 to 1 January 2012 the population of Telford and Wrekin alone increased from 154,788 to 165,570, an increase of 7%.
- Paediatric emergency services were based at Princess Royal Hospital although there was not a separate paediatric emergency department for children and young adults. A small, child-friendly waiting room was available with play equipment and murals to distract and entertain very young children. A paediatric treatment room was also available adjacent to the waiting room, this had been decorated to reduce the clinical appearance of the room.
- The trust had established a stroke centre at the Princess Royal Hospital which meant that where possible patients suspected of having suffered a stroke anywhere in the hospitals catchment area; they would be conveyed direct to the Princess Royal Hospital. Many such patients would be admitted via the emergency department.

Stroke pathways require that where certain types of stroke are suspected, patients should receive a CT scan within one hour. There was only one CT scanner available at the Princess Royal Hospital, and during our inspection the scanner failed. Staff told us that such failures were common.

The imaging business continuity plan was activated. Ambulance services were advised to take any suspected stroke patients to Shrewsbury. The plan also required that patients diagnosed with a stroke who were already

at Telford but had not been scanned had to be transferred to Shrewsbury. One patient at the Princess Royal Hospital had to be transferred to Shrewsbury during the inspection.

We asked the trust for details of how often the CT scanner had broken down or was unavailable and how many patients this had caused to be diverted or transferred. We were provided with information which showed that from 1 February 2016 to 15 December 2016, the CT scanner had been unavailable for various periods of time on 12 separate dates. These included eight occasions for planned service or maintenance and four occasions due to breakdowns. Of these, 10 had required stroke patients to be diverted or transferred to Shrewsbury. The trust were unable to provide details of the number of patients who had been diverted or transferred.

Meeting people's individual needs

- We saw that treatment pathways and care plans reflected the needs of individual patients. However we saw several occasions where risks had been identified and documented but no interventions to mitigate the risks had been put in place other than providing coloured arm bands to patients.. Two patients who had been identified as susceptible to falls were seen wandering in the department and whilst staff were able to identify them relatively quickly from coloured arm bands which they wore, there was no close monitoring or one to one nursing to ensure the patients did not wander or to reduce the likelihood of injury if they left their bed.
- We saw one patient who was unable to speak English. Whilst staff explained that the patient was able to understand English and they were able to inform them of their treatment and care, there had been no attempt to arrange any translation service for them. When this patient was eventually discharged we were told that a fellow patient who could speak their language had acted as an interpreter.
- We asked senior staff about interpreting services and they told us the last time they had tried to use a telephone service they had been asked for a password which they didn't have. The Matron commented that she was not aware of any problems with telephone interpreter services and would investigate the issues and ensure staff were updated.
- The trust did not have a dedicated paediatric emergency department. The Princess Royal Hospital was designated by the trust as the preferred location for paediatric emergencies and service level agreements existed with ambulance services to ensure that unless it was not safe to do so, all paediatric emergencies in the area should be taken to the Princess Royal. However facilities for paediatric patients did not meet the guidance of the Royal College of Paediatrics and Child Health (RCPCH).
- In September 2016, the CQC completed a review of health services for looked-after children and safeguarding in Telford and Wrekin. The review included provision within the emergency department at the Princes Royal Hospital. The trust completed an action plan to address the recommendations of the report.

  This included issues of children and young people having to wait in the adult waiting room prior to streaming or triage. The Royal College of Paediatrics and Child Health's (RCPCH) 'Standards for Children and Young People in Emergency Care Settings' 2012 states children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. The document also states children's areas should be monitored securely and zoned off, to protect children from harm, and access should be controlled".

  One recommendation was that the trust should ensure the facilities and environment meet the requirements of the Royal College of Paediatrics and Child Health (RCPCH) standards for children and young people in emergency settings.

- The action plan included provision of an audit of facilities against the recommendations of the RCPCH. However it highlighted that the trust were unable to implement all the recommendations due to department and estate constraints. They were considering converting one additional cubicle to be more child friendly. Provision had been made for very young children once they had been triaged/streamed as there was a child friendly room with play equipment. However, older children and young adults told us they preferred to wait in adult areas as the play room appeared too childish and they were embarrassed to use it.

- We spoke with one young person who was in a hospital wheelchair in the general sub-wait they confirmed that they would rather remain in that area with their parent. The parent commented that they could not use the play room even if they had wanted to as the door was too narrow for the hospital wheelchair to get through.
- Patients identified with dementia or memory problems had 'Butterfly' stickers on their notes and emblems over their bed to highlight to staff that the person may need additional time or support to understand. We heard senior nursing staff updating nurses about patients who required additional support during handovers. We saw that these patients were given time to consider what staff were saying or doing.
- We saw that patients who had been assessed as being at risk of falling were given a yellow arm band. However we saw one such patient leave their bay on two occasions trying to get the attention of staff. The patient was wearing a hospital gown and the arm band was clearly visible yet several staff who were busy going between patients did not stop to assist the patient or return them to their bay. A non-clinical member of the operations management team finally went to the patient; linked their arm and led them back to their bed.

Access and flow

- From 1 June to 30 November 2016, 40,981 patients attended Princess Royal Hospital emergency department, an average of 6,830 per month. Of these, 8,553 (1,426 per month) were admitted to the hospital for further treatment, care or observations. A further 4,565 (776 per month) left the department without being formally discharged or without having treatment. This included 10,378 children, of these 1,618 were admitted and 859 left without discharge or treatment.
- The trust performance from August 2015 to July 2016 for patients leaving the trust's urgent and emergency care services before being seen for treatment was lower than the England average. From August 2015 to March 2016 performance against this metric showed a trend of slight decline, with the percentage peaking at 3.2% in March 2016 (England average 3.6%), before falling to a low of 2% in April 2016.
- From August 2015 to July 2016 the trust's monthly median total time in emergency department for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline. The median time peaked in March 2016 at 162 minutes; the England average saw a similar peak of 157 minutes.
- NHS England best practice requires that 95% of patients who attend emergency departments are admitted, transferred or discharged within four hours. The hospital was consistently failing to meet the target.
- From September 2015 to March 2016 performance against this metric showed a trend of decline, though this rose again from April 2016 to August 2016. The trust's figures were consistently below the England average from September 2015 to August 2016.
- From September 2015 to August 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Performance against this metric peaked at 47% in March 2016, before falling to 15 % in June 2016. The trust average was 21%, against an England average of 8%.
- Over the 12 months, no patients waited more than 12 hours from the decision to admit until being admitted.
- We also saw that records of patients waiting to be seen occupied a section of wall adjacent to the hub. However there was no structure to the system, it did not identify and prioritise the acuity of patients. One consultant told us that it was possible for junior doctors to "cherry pick" the patients they wanted to see and avoid complex cases. They described occasions when they had reviewed the notes of waiting patients and placed them in order of priority in the wall racks only to find later that they had been rearranged in order of attendance.
- Some consultants told us that the system operated in the department for patient notes was unsafe. When patients had been triaged or after being handed over by ambulance staff, their records were placed into the wall rack waiting for allocation to a doctor. They told us when patients were waiting to be assessed there was no way to see which patients were of a higher priority without physically referring to each set of records, which at busy times was virtually impossible. This situation was compounded when patients had been seen and their notes placed into the cubicle rack. Any change in their condition and in particular early warning scores;

which identify deteriorating patients could be overlooked. This was because as nurses replaced the notes unless the doctor was present in the area they might not update them appropriately.
- One consultant said "It's not possible to identify where in the department our sick patients are. Most patients are treated in order of attendance".
- Commissioners had provided funding for a GP to work in the emergency department alongside the permanent medical team, to enable suitable patients to be streamed to the GP who would conduct an initial consultation and, where appropriate, refer the patient back to their own GP or other health services. This helped to increase the flow of patients through the department.
- One elderly patient had been in the department for 22 hours. We saw that no nursing notes had been completed for over eight hours. The patient told us that the staff had been wonderful but appeared to have forgotten them. They told us they had had to ask for food and drinks. There was no set procedure to support patients in these circumstances. Nurses were busy ensuring that patients who required observations or treatment received their care. Patients who did not require nursing care were almost forgotten.

Learning from complaints and concerns

- The trust had a complaints policy which was available to staff on the intranet. A Patient Advice and Liaison Service (PALS) supported patients, carers and family members if they had complaints or concerns about the service. PALS leaflets were available in the emergency department waiting room.
- The trust website also contained information about PALS and how to raise concerns or complain.
- We saw how complaints were discussed during team meetings to raise staff awareness and help prevent recurrences. From 1 June to 30 November 2016, there had been 14 complaints about the Princess Royal Hospital emergency department. Ten had been finalised, four were on-going and two complaints had been re-opened when complainants had been dissatisfied with the outcomes provided.
- Senior nursing staff were able to explain the procedure for developing staff whose performance had led to complaints or concerns. We saw paperwork relating to performance management of staff.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a lack of leadership and direction for consultants which had led to a lack of cohesion in working practices such as around the use of electronic whiteboards.
- Some consultants objected to operations managers attending their meetings even though others believed this would improve relationships and understanding.
- The Future Fit review had led to uncertainty amongst staff and impacted on morale, although managers tried to support staff with information.

However:

- Teams worked closely together and nursing staff felt engaged and supported.
- Staff were aware of and understood the trust-wide vision and values.
- There was a clear governance committee structure with direct reporting to the care group board.

Leadership of service

- The emergency departments at Shrewsbury and Telford were managed by the trust as one service. An operations manager based at Shrewsbury managed the logistical side of the department, supported by a deputy based at Telford. Each location had a matron who oversaw nursing and care services. Consultants and medical staff worked at both sites on a rota basis with the exception of some consultants who were contracted to work at one or the other of the sites and were therefore excluded from the rota.
- We saw that the teams worked closely together at Telford. However, we were told that some consultants objected to operations managers attending their meetings even though others believed this would improve relationships and understanding.
- Managers in the department understood their staff and the unrest which the Future Fit review had caused and continued to cause. Staff told us that they believed their

managers had been as supportive as they were able, but they felt that senior executive level managers had decided the department was closing and 'they wanted it done sooner rather than later'.

- Nursing staff told us they were supported by their managers and felt engaged and valued in the department. There was uncertainty about the future but they explained that managers had reassured them that although decisions were being made about the department, any changes would take a considerable time to implement. Staff told us that executive level leadership was not very visible.

Vision and strategy for this service

- Staff were aware of the trust's vision and how their role contributed to achieving it. The trust vision and values were available to staff on the intranet,
- The emergency department's philosophy was "We will provide timely emergency care based on your individual clinical need. Our team will deliver this with kindness, compassion and respect for all". Managers told us staff were involved in writing the philosophy.
- The strategy for the department was less clear. There was uncertainty amongst staff as to whether the Princess Royal Hospital would retain an emergency department and what that meant for their own employment, this had become the overarching concern in the department. The review was launched in 2014 to review health systems across Shropshire, Telford and Wrekin and mid-Wales, and was set to finish in spring 2017.

Governance, risk management and quality measurement

- There was a clear governance committee structure with direct reporting to the care group board. Sub-board committees reported to the care group with both non-executive and executive membership.
- Emergency department managers at both hospitals held operational management meetings fortnightly, alternating between the two sites. During our inspection, the meeting was held at Shrewsbury Royal Hospital. CQC inspectors at Shrewsbury observed the meeting. The meeting was attended by the emergency department matron and manager from Shrewsbury, and two senior managers from the trust. Items discussed included both sites and covered subjects including medical and nursing staffing, Emergency department and ambulance handover performance and the department's risk register.
- The board of directors and executive level director groups received monthly performance reports on national and local targets. Action plans were put in place to improve performance where needed across the unscheduled care group. Unscheduled care is any unplanned contact with the NHS by a person requiring or seeking help,careor advice. Unscheduled careincludes urgent and emergencycare.
- We were shown a copy of the department's 'integrated performance report', which gave managers details of the emergency departments monthly figures on staff sickness and management, patient safety indicators, patient experience indicators, staff training and appraisals.
- Emergency department meetings at the Princess Royal Hospital took place every four to six weeks. Minutes were taken and circulated on the 'Team Brief' to all staff in the department; which meant that staff who were unable to attend were updated on the contents of the meeting. We were told that meeting agendas followed the trust format which provided continuity between management levels.
- We viewed six sets of minutes from different meetings which had taken place between March and October 2016. We saw agenda items such as; incidents, staffing, training and risks, this enabled information to be flow between the different levels of the organisation.
- The emergency department matron shared an office with the deputy operations manager and they were able to discuss issues on a daily basis, however formal meetings still took place monthly and were minuted. Consultants held monthly meetings but these did not include operations management representatives. Some consultants had suggested their presence would be beneficial whilst others felt the meetings should remain focused on medical issues.
- We were given a copy of the trust's 'rapid implementation internal ED improvement plan', which detailed 49 areas for improvement across the emergency departments in both hospitals. Each item was graded by colour: blue indicated the item was

implemented and operational; green meant it was on track for implementation within the agreed timescale; amber showed it was in the planning stage; and red showed there was no evidence of progress.

- In December 2016, four of the 49 items were shown as 'blue', and nine were 'green'. Seventeen items were 'amber', showing they were in progress and only five were 'red'. Three of the 'red' rated items were not due for completion until March 2017; however two of them should have been completed in November and December 2016, so were overdue. These related to the implementation of a set of 'internal professional standards' and to undertake demand and capacity modelling by hour of the day and day of the week. The trust's chief executive reviewed the plan every month, at a meeting including all specialties from the hospital. This meant all departments were engaged with the ED improvement plan and that the key issues were being monitored and regularly reviewed.

Culture within the service

- Staff were proud of the service they provided and the team.
- We observed how medical staff and nursing staff interacted and consulted with one another regarding patients in the department. We saw that exchanges were polite, professional and friendly. Nursing staff told us that relationships had improved since the introduction of the central hub. Medical staff were more visible, easier to find and more involved with general discussions in the department which had contributed to the collaborative working.
- We found that relationships between consultants in emergency department was a source of conflict with regard to differing opinions on working practices. For example, some consultants used the electronic white board and asked junior doctors to update information on it whilst others opted to not use the white board and their junior doctors would follow suit.
- We saw that regular meetings had taken place between the consultants and we reviewed minutes of the meetings. Working practice had been raised as an agenda item but attempts to resolve differences had failed. We saw that leaders within the department had not dealt with these issues in a timely manner which had led to clinicians not working cohesively.

Equalities and Diversity

- We saw records which showed that equality and diversity training formed part of the mandatory training for staff. Records showed that 90% of nursing staff in emergency department had completed the training.
- Staff we spoke with; some of whom were from minority groups, all told us that mutual respect and professionalism in the department meant that patients, staff and visitors were all treated equally.
- During our inspection and observation of staff interactions with each other and with patients we did not see or hear of any inappropriate comments, behaviour, or actions.

Public engagement

- Between October 2015 and November 2016, the department received 8,378 responses to the NHS 'Friends and Family Test' patient experience survey. This represents a response rate of 22%, significantly better than the England average for emergency departments, which is 13%. In August and September 2016, the response rate was over double the England average, and in December 2015, the response rate peaked at 45%, over three times the England average of 13% for the same month.
- The trust website had information about the services available at the hospital including news about the emergency department, this also provided advice and guidance to patients about alternatives to attending emergency department to relieve pressure on the service.
- Members of the public could get directly involved with the trust in a variety of ways. The trust invited members of the public to become members, they had over 9,000, a patient experience panel provided feedback directly from patients and carers about the service they had received and the trust had over 800 volunteers who provide a variety of services to support the hospitals, although we were told that volunteers did not work in the Princess Royal emergency department.

Staff engagement

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

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

Innovation, improvement and sustainability

- Plans to restructure emergency care provision across the county were in consultation as part of the 'Future Fit' programme, which took into account the changing demographic of patients in the area served by the trust. Changes proposed by the programme included retaining services at both Princess Royal Hospital and Royal Shrewsbury Hospital as urgent care centres, and creating one new, purpose-built emergency centre in the county.
- Staff used a 'smart' LCD screen to monitor patients in ED at Royal Shrewsbury and Princess Royal Hospitals. This allowed department co-ordinators and managers to have an overview of the two departments, and to track patients and their clinical conditions. Every member of staff was able to update the board, and every entry was confirmed with a PIN number unique to the staff member.

Medical care (including older people's care)

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

Information about the service

The medical care service at Princess Royal Hospital (PRH) provides care and treatment for general medicine, cardiology, dermatology, gastroenterology, thoracic medicine, haematology, respiratory medicine and nephrology. The trust had 65,366 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 26,378 (40.4%), 37,633 (57.6%) were day case spells, and the remaining 1,348 (2.1%) were elective. Data showed that 25,198 (39%) of admissions were in general medicine. Data for the individual hospital sites was not provided.

The service had previously been inspected in October 2014 and was rated requires improvement for safe, effective and responsive.

We conducted an announced visit on 14 and 15 December 2016 and followed this with an unannounced visit on 3 January 2017.

During the visit, we considered the full environment including the facilities available to patients and staff along with staffing levels to provide a safe service.

We looked at the nine wards, including elderly care, acute medical unit (AMU), stroke, general medicine and a winter pressure wards, that provided medical care across the Telford hospital site.

We spoke with 11 family members, 17 patients, and 40 members of staff at different grades, as well as observing the daily routines of the hospital.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust.

Medical care (including older people's care)

Summary of findings

We found that incidents were reported, analysed, and learning was shared with staff. We saw an electronic board system, which displayed patient information and allowed quick and easy access for all staff. We saw staff caring for patients in all areas that we inspected

We saw staff using hand held electronic devices to record and monitor patient observations. This was linked to the early warning system which would alert staff if the patient results became concerning.

However, the numbers of nurses on medical wards regularly fell below the safe minimum number established requiring agency staff to be used. Ward managers told us that they relied on bank and agency to cover shifts

There was not a consistent approach to oxygen prescribing on wards, in particular ward 6. Staff knew the requirement to prescribe it but when patient notes were checked there had been no evidence of prescribing on the adult prescription and administration record.

Staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 100%. Between September 2015 and November 2016, medical services achieved 58% in safeguarding adults at level 2 and 44% in safeguarding children at level 2.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- There were adequate numbers of signs referring to using hand gel. However, there was an inconsistent use of hand gel on all wards. We saw staff entering and leaving areas without using them.
- We found that patient records were not kept secure on every ward we visited
- Staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 100%. Between September 2015 and November 2016, medical services achieved 58% in safeguarding adults at level 2 and 44% in safeguarding children at level 2.
- There was not a consistent approach to oxygen prescribing on wards, in particular ward 6. Staff knew the requirement to prescribe it but when patient notes were checked there had been no evidence of prescribing on the adult prescription and administration record.
- We checked on nasogastric tubes to see if the tube length and positioning had been recorded. We found that in four out of four cases, staff had not noted or signed for on the adult 24 hour fluid balance chart.

However:

- Although substantive nurse staffing levels throughout the medical directorate were below agreed planned numbers, the trust were able to ensure shifts were covered through bank and agency staff.
- Staff had access to learning from incidents, complaints and alerts in a safety brief that was published for all staff.
- Staff had access to sufficient quantities of equipment, which was well maintained and available to staff.
- Systems were in place to monitor patient risk and identify and respond to deteriorating patients.
- Medicines were managed in a way that kept people safe from the risk of harm.
- Generally, we saw good housekeeping on the wards and the cleaning schedules were displayed.
- We saw good examples of mandatory training records displayed on wards 7, 15 and 17 which linked to appraisals and were monitored and up to date.

Medical care (including older people's care)

Incidents

- The trust used an electronic incident reporting system for reporting all incidents. The system could be accessed by staff through the intranet and trust website.
- Clinical staff told us that they understood the reporting process for incidents, near misses and never events. We found that staff were encouraged to report incidents and learn from them.
- Lessons from incidents were part of governance and quality meetings with examples of root cause analysis (RCA) discussed. Managers would share the information through team meetings and the safety briefing. We saw minutes from the November 2016 medical quality and safety governance meeting, where two RCA's had been discussed.
- Staff had access to learning from incidents, complaints and alerts in a safety brief that was published for all staff. The information was discussed at team meetings and the safety brief displayed in staff areas. We saw three examples of safety notices being displayed in the staff offices, after discussing at the team meetings.
- In accordance with the serious incident framework, the trust reported 17 incidents in medical services, which met the reporting criteria set by NHS England between October 2015 and September 2016. There were 10 serious incidents (SIs) reported by staff at PRH. Data was not provided for the total number of incidents at PRH for this period.
- Monthly mortality and morbidity meetings are coordinated by a doctor and cases are reviewed to identify learning points and trends. We saw minutes from meetings going back 6 months and noted that important information was shared by an email to all doctors.
- Staff we spoke with understood the duty of candour (DoC) regulations and the procedure for following it. Managers were responsible for ensuring that patient and relatives were informed following an incident. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- We were told of an example where a doctor had arranged a meeting with a patient's family to discuss an incident that had happened on the ward. A duty of candour letter had also been drafted to the family in line with the policy.
- There were no recorded never events for medical care between October 2015 and September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The trust displayed the safety thermometer on all but one of the wards we visited, on ward 11 there was no display visible. However, this is an improvement from the previous inspection.
- Data for the trust showed 53 pressure injuries, 20 falls and 23 catheter urinary tract infections in medicine between September 2015 and September 2016. Data for the individual hospital sites was not provided.

Cleanliness, infection control and hygiene

- Generally, we saw good housekeeping on the wards and the cleaning schedules were displayed. Cleaning was taking place as stated on the schedule and we saw that the housekeeping staff were visible throughout the hospital.
- Wards were visibly clean and tidy with the exception of ward 7. This ward was unkempt with equipment stored untidily and stacked outside of rooms. We saw used bags of blood incorrectly disposed of or left on surfaces in the sluice room and the bin had a broken lid, which exposed the contents.
- There were adequate numbers of signs referring to using hand gel. However, there was an inconsistent use of hand gel on all wards. We saw staff entering and leaving areas without using them, but they were following guidelines to be bare below the elbow.

- Staff used side rooms as isolation areas for patients that had been identified as an increased infection control risk, for example, patients with methicillin-resistant staphylococcus aureus (MRSA).
- Patients were screened for MRSA and other infections on admission to the wards. Side rooms were used for isolation of patients that had been identified with MRSA.
- We saw that most sluice rooms were locked when not in use and charts documenting the legionella tap flushing requirements completed to date and displayed.
- At trust level 60% of acute medicine staff had completed their infection prevention and control training, compared to the trust target of 80%. Staff could describe the methods and we saw them following process for using aprons and gloves, but the use of hand gels when leaving or entering the ward was inconsistent. Data for the individual hospital sites was not provided.
- Audits of compliance were described as ward walks and were completed regularly by managers on medical wards. General cleanliness, hand hygiene and the use of gloves and aprons were looked at. The results showed inconsistent use of hand gels on some wards. Results were discussed at infection prevention and control (IPC) meetings and if a ward scored less than 80% compliant, the IPC lead would visit the area to follow up and advise staff.

Environment and equipment

- Access to most of the wards was restricted and entrances were secured with all non-staff members required to use the intercom to gain entry. However, we saw two wards that did not have the main doors locked and they were easy to access. We walked onto ward 9 without challenge and ward 11 had no staff visible to greet us when we entered.
- Staff told us that they had concerns regarding visibility on the elderly care ward. We were told that the design did not enable staff to see patients from the nurses station. The ward manager told us that she thought the concerns were on the risk register.
- Most areas appeared clean, tidy and free from obvious hazards. However, on one ward we found medical gas cylinders leaning against a wall and not safely stored.
- We checked the emergency arrest trolleys on every ward we visited. We saw most daily checks had been completed and recorded, medicines and consumables were in date and properly packaged and portable appliance testing (PAT) was in date. One ward out of the nine had not recorded daily checks for two days in the week before our visit.
- Staff told us they had good access to equipment, such as hoists and pressure relieving aids, to do their job. They described the process for obtaining equipment, but told us that often, in an emergency, they would liaise with other wards and share.
- During the inspection, the CT scanner was reported as broken. Contingency plans which informed local emergency services to redirect relevant patients to Shrewsbury hospital, were followed correctly. Inspectors saw the process completely and staff, in particular those on the stroke ward, were efficient in following the SOP. However, managers told us that there was only one CT scanner at the site despite being a stroke centre and this was identified as a risk. There was a contract in place for emergency repairs to be done within four hours and this was managed robustly.
- On one ward, we found a cleaning store cupboard containing fluids and other harmful items unlocked, despite a notice on the door which read "Keep locked at all times". This was rectified once the ward manager had been made aware and we were told that staff would be reminded at handover.

Medicines

- The trolleys used for drug rounds were clean and well organised, with labels on medications. Staff had checked and signed for the medication and equipment daily, including fridges where medication was stored.
- We saw that controlled drugs (CDs) were appropriately stored with access restricted to authorised staff and accurate records were maintained. Staff performed daily balance checks in line with the trust policy.
- Pharmacy support for wards was available on-site Monday to Friday from 9am to 5pm, with a pharmacist available on-call service outside of these hours.
- We reviewed 10 medication charts and found all had been documented correctly and one had a penicillin allergy highlighted.
- We saw six patients receiving medicines and found the process to be safe with two members of staff administering controlled drugs (CDs). Staff interacted well with patients and checked patient identification before giving out medication. The nurse also ensured that medication had been swallowed before moving on.

- We saw nurses wearing disposable red aprons which had "do not disturb" printed on them while administering medicines, this ensure that the nurse would not be distracted and likely to make errors during the process.
- There was not a consistent approach to oxygen prescribing on wards, in particular ward 6. Staff knew the requirement to prescribe it but when patient notes were checked there had been no evidence of prescribing on the adult prescription and administration record.
- Staff told us that oxygen was prescribed but drugs charts or notes were not updated. For example, we saw a patient being given oxygen 40% at 10 litres per minute with no documentation to state this rate was prescribed. They said that the information was verbally communicated and that patients would always get the correct amount specified by the doctors and set up whilst the doctor was there.

Records

- We randomly checked 14 sets of patient notes on the elderly care, stroke rehabilitation and coronary care wards finding records contained risk assessments, records of care and treatment and were legible, signed and dated.
- We found that patient records were not kept secure on every ward we visited. On three occasions and different locations, we found patient notes in an unlocked room and not attended to by staff. This meant that unauthorised persons could remove or view records without staff knowing. Staff moved the notes to the nurses station or locked the room when we informed them.

Safeguarding

- There has been an agreed adult safeguarding policy and procedure throughout Shropshire, Telford and Wrekin since April 2013. All agencies within the local adult safeguarding board, including PRH, had adopted this policy.
- Staff had access to safeguarding policies online and they could demonstrate how to access and use them. They knew how to escalate and were clear about what was a safeguarding concern.
- Safeguarding adults, children, and vulnerable adults, training was part of the mandatory training for all staff, but not all staff were up to date with the training.
- Staff in medical services were not fully compliant with the trust's mandatory safeguarding training target of 100%. Between September 2015 and November 2016, medical services achieved 58% in safeguarding adults at level 2 and 44% in safeguarding children at level 2. Data for the individual hospital sites was not provided.
- Between December 2015 and December 2016 there, were 34 safeguarding referrals made and dealt with at PRH.

Mandatory training

- We saw good examples of mandatory training records displayed on wards 7, 15 and 17 which linked to appraisals and were monitored and up to date. Other wards did not display the information as clearly, but managers could access it on the computer or in folders.
- Staff we spoke with told us that they were up-to-date with mandatory training and would receive reminders from ward managers about the training expiry date.
- Mandatory training for all staff included subjects like safeguarding, infection prevention and control, moving and handling, fire safety and security. The trust had a target of 100% compliance with mandatory training but did not achieve this in all areas. Compliance rates ranged from 57% to 91% on the different topics across the trust, however at PRH the compliance was over 85% on all the wards we visited.
- A nurse in charge of one ward explained that mandatory training was not up to date due to staff being off work long term or on maternity leave. Several staff had returned to work but had not yet received training due to covering the shortfall. However, we saw a plan to ensure the training was completed.

Assessing and responding to patient risk

- The trust used a national early warning system (NEWS) to highlight significant changes in a patient's medical condition. We reviewed eight patient records and staff had used the NEWS score appropriately. Staff had a good understanding of the system.
- We saw staff using hand held electronic devices to record and monitor patient observations. This was linked to the early warning system which would alert staff if the patient results became concerning. The system also recorded when staff should take the next set of observations, according to the patient's individual level of risk. Staff told us that the system was good, but more would like more handheld devices on the ward.

- Staff carried out risk assessments upon admission to identify risk and develop care plans to ensure they received the right level of care.
- We reviewed 10 falls assessments, randomly chosen from different wards, we found that nine had been were completed fully and to a good standard. The information was up to date, clear and the outcome had been noted on the patient's bedside notice board. However, one had some information missing such as names and dates.
- We checked on nasogastric tubes to see if the tube length and positioning had been recorded on patient notes. We found that in all four cases checked, there was no record of this information.

Nursing staffing

- The hospital used safer nursing care tool (SNCT) in all areas as part of a six-monthly staffing establishment review carried out in medical services to determine staffing levels.
- Staffing levels for the day were clearly displayed for visitors to the ward. We saw that the planned levels were achieved on the wards by using bank or agency staff. The elderly care and stroke wards used regular staff to cover any shortfall. We saw on AMU that the staffing levels were as agreed.
- We were told that matrons monitored staffing levels across all areas on a daily basis to ensure that action was taken to mitigate risk. For example, on AMU there was agency covering a shift because a regular member of staff had been redeployed to the emergency department as part of this process.
- Ward 11 is used to help with winter pressures at PRH. Managers on all wards told us that they were required to allocate 5% of the ward staff to cover ward 11. This was to enable adequate substantive nurse staffing for ward 11 to cover during the winter period, rather than staff with all agency staff.
- A nurse in charge of a ward told us that staffing issues were the biggest challenge they faced on a daily basis was allocating staff to ward 11. However, they also told us that the issue had been raised with managers and that action had been taken to help, such as staff redeployment being managed by a matron. Ward managers told us that they relied on bank and agency to cover shifts when substantive staff had been redeployed elsewhere in the hospital.
- On several wards we visited, the nurse in charge was often required to cover nursing duties. We saw that they were proactive and made every effort to redeploy staff and communication between wards was good. The matron had responsibility for staff exchanges or redeployment.
- We saw that the ward manager on one ward was assisting with the medication round. A nurse was taken off a training session to cover the shortfall, but it took over an hour to find the replacement.

Medical staffing

- We looked at the weekly rota and saw an improvement since the last inspection in the cover for out of hours and weekends at PRH. All shortfalls were highlighted on the rota and discussed at weekly meetings held on a Monday morning and plans put in place to cover.
- We were told that there were 37 doctors, excluding consultants, working in medicine at the time of inspection. Locum support was used to improve medical cover in some areas.
- The trust had identified there was a reduction of 19 doctors in 2015, due to them moving to other trust's or natural wastage and is below the national average for recruitment of junior doctors, however, the hospital was actively recruiting new staff.
- Consultant cover was provided using a rota for out of hours working. Consultants covered from 9 am to 5 pm on weekdays and 9am to 3pm on weekends with all other times having a duty on call
- We saw good, consultant led, medical handovers and information was available on the electronic boards and a spreadsheet was used to capture other patient information.
- Junior doctors told us that they were supported by consultants and felt included in making decisions for patients. This was highlighted in stroke services which includes four consultants across the two hospital sites who work closely together to coordinate patient care across the trust. Doctors told us that the communication and support had improved considerably over the last 12 months.
- We were told that the general practitioner (GP) that usually worked in the AMU had been permanently moved to A&E and this was causing delays to discharges. The GP would be able to make the decision for discharge more efficiently than waiting for another doctor to attend.

Medical care (including older people's care)

- We saw in records that a consultant reviewed patients within 12 hours of admission to hospital or to a medical ward.

Major incident awareness and training

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

Are medical care services effective?

Good

We rated effective as good because:

- We saw that care and treatment provided on medical wards followed guidelines published by the National Institute for Health and Care Excellence (NICE).
- Patients told us their pain was assessed and well managed.
- Since 2014, the availability of a seven day service has improved. Weekend and out of hours medical support has improved with the introduction of a rota for on call staff.
- Patients told us that the food was good. There was enough choice for those with special diets and generally, they got exactly what they had ordered
- We saw an electronic board system, which displayed patient information and allowed quick and easy access for all staff and enabled effective multi-disciplinary working.
- Patient's specific needs were also displayed in different colours to allow staff to see instantly if someone was diabetic or on a special diet and their level of vulnerability.
- We saw good examples of Mental Capacity Act (MCA) and Depravation of Liberties (DoLs) assessments being completed

However:

- Not all areas were meeting the trust target of 100% with staff appraisals.
- The trust scored the lowest grade in the Sentinel Stroke National Audit programme but individual indicators showed some improvement.
- The trust were not submitting data to national audits on lung cancer and myocardial ischaemia.

Evidence-based care and treatment

- We saw that care and treatment provided on medical wards followed guidelines published by the National Institute for Health and Care Excellence (NICE). Staff had access to relevant guidelines through the internet.
- The medical service participated in national clinical audits, to measure the effectiveness of care and treatment provided. These included the diabetes audit (NaDIA) and the Sentinel Stroke National Audit Programme (SSNAP).
- We saw completed assessments that covered patient needs, including mental health, physical health, and nutrition and hydration.
- Endoscopic procedures were completed in line with national guidance and best practice. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) found that endoscopy services met the accreditation standards. JAG accreditation is the formal recognition that an endoscopy service has met the competence to deliver against the measures in the Global Rating Scale (GRS) standards.

Pain relief

- The hospital had an acute pain team who provided advice and support to staff in managing patient's pain.
- We spoke with six patients and they all told us that if they had asked for pain relief it had been given. They all said that they had described their pain to staff using a pain scale. Staff used the information to assess patients' pain and had recorded this on all six patient notes that we looked at.

Nutrition and hydration

- Speech and language therapists assessed patients' ability to swallow safely and documented guidance on their requirements.
- We saw patient's food charts completed correctly with entries for every mealtime and there was information

written on the notice board about diet. We reviewed five patient records and found that malnutrition universal screening tool (MUST) risk assessments were completed.

- Patients told us that the food was good. There was enough choice for those with special diets and generally, they got exactly what they had ordered. Hot and cold meals were available on the menu and hot and cold drinks were regularly offered to them.
- All wards provided protective meal times to allow patients to eat their meals without interruption and enabled nursing staff to assist patients who were unable to eat independently.
- We found that patients waiting in the discharge lounge often went without a meal because they had been waiting over lunchtime to be discharged. The meal that had been ordered on the ward did not always get collected in order for the patient to eat whilst waiting. Some patients had waited for several hours before discharge.

Patient outcomes

- The trust took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). The SSNAP is the single source of stroke data in England, Wales and Northern Ireland. There are three main components of SSNAP, the clinical audit, acute organisational audit, and post-acute organisational audit. On a scale of A to E, where A is best, the trust achieved grade E in the latest audits, January 2016 and March 2016.
- On individual indicators, however, the trusts performance had improved, showing a greater number of C and D grades in the January to March 2016 report, compared with mostly 'E' grades in the April to June 2015 report. The trust produced an action plan to address these findings. Action points included the Clinical Governance Executive receiving quarterly updates of results. A quality improvement programme was also in place, alongside ongoing recruitment of stroke consultants. Data for RSH only was not available.
- Results of the National Diabetes Inpatient Audit (NaDIA) for PRH in 2015 showed the trust performed better than the England average percentage for 10 out of 17 scored measures.
- The results in the 2015 Heart Failure Audit were better than the England and Wales average for all of the four of the standards relating to hospital care. The hospitals results were better than the England and Wales average for six of the seven standards relating to discharge. Cardiology inpatient at the RSH scored 53% against the England average of 49%, input from consultant cardiologists was 63% against the England average of 60%, input from a specialist achieved 100% compared to the England average of 78% and patients receiving an echo achieved 100% compared to the England average of 92%.
- ACEi (Angiotensin-converting enzyme inhibitors) and ARBs (Angiotensin II receptor blockers) are drugs that help to improve survival of patients with heart failure and staff should prescribe them to patients on discharge as appropriate. The audit showed that the hospital was better than the England average for prescribing these drugs on discharge and referral to a heart failure liaison service achieved 99% compared to the England average of 59%. However, referral to cardiology follow up only achieved 47% compared to England average of 100%.
- The trust was working to improve care for patients, in partnership with the Virginia Mason Institute (VMI) as part of a five-year plan. The trust had completed work on respiratory care and had been able to demonstrate a positive impact on patients' outcomes. Staff reported a 98% reduction in time from patients arriving on the respiratory ward to the point they were informed of a plan/date for discharge (1229 to 20 minutes) and a reduction from 540 to 50 minutes to commence the fact finding assessment.
- The trust was also working on the treatment of sepsis. Staff reported a 92% reduction in time from diagnosis of sepsis to commencement of all elements of the sepsis bundle (296 to 23 minutes); 100% of patients received all appropriate elements of the sepsis bundle within one hour; a reduction in steps taken by a patient reduced from 84 to 22 steps before they were reviewed for signs and symptoms of sepsis and the time to complete nursing documentation associated with the screening and diagnosis of sepsis reduced by 84% (45 to 7 minutes).
- Results of the myocardial ischaemia national audit project (MINAP) were not available because the trust did not take part in this audit. The trust did not take part in the national lung cancer audit.
- From April 2015 to March 2016, PRH had a lower rate of readmission for both elective and non-elective patients.

Competent staff

Medical care (including older people's care)

- We saw a clear plan of completing appraisals for staff on most wards at PRH. Staff could see the dates of when their next appraisal was due and staff told us that they had regular appraisals.
- The trust had a target of 100% completion for training and appraisals. However, some areas were not compliant. For the period September 2015 and November 2016, the appraisal rate for nursing staff in medical services across the trust was 75% against the trust target of 100%.
- For the period September 2015 to November 2016, 96.% of doctors in medical services across the trust, had an up to date appraisal. Junior doctors were at 96% and consultants at 97%. The target compliance level for appraisal was 100%.
- Agency staff were given a local induction delivered by ward managers or senior nurses. Staff told us that they thought the induction was good We saw that on two wards senior staff had been given the opportunity to cover for the ward manager. They told us that this was a good chance for them to gain experience.
- Nurses told us that they were supported with the revalidation process. Revalidation was introduced by the Nursing and Midwifery Council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration.
- We saw a new member of staff that was working alongside a nurse as part of their induction. The induction process was thorough with a combination of practical and educational guides to complete, along with a dedicated peer support.
- We saw a ward clerk on ward 15 that had been encouraged to support in the development of a stroke database that helped inform SSNAP and other stroke indicators. They were proud to have been involved in the process and told us that they felt like a valuable member of the team.

Multidisciplinary working

- We observed several handover meetings and board rounds. We saw that there were staff from all areas that were involved in patient care and that they had input to the meetings. We saw good use of the electronic patient information board during the meetings.
- The communication between nursing and medical staff was good. We saw on several occasions when a patient was discussing their care with doctors and nurses and on one occasion with a family member included.
- The trust used a patient status at a glance (PSAAG) to support a patient centred approach in MDT meetings. PSAAG combined the information from handover, electronic observations, nursingassessments, and discharge information to provide the best care for patients.

Seven-day services

- Since 2014, the availability of a seven day service has improved. Weekend and out of hours medical support has improved with the introduction of a rota for on call staff.
- Consultants were available at weekends between 9 am and 3 pm and on call overnight. For weekdays , between 5 pm and 9 am the following day, a consultant was on call.
- Therapy services were available Monday to Friday, with a reduced service at weekends. We saw good processes for referral to these services and found they met the needs of patients better than in 2014. Discharge meetings were attended by a multi-disciplinary team and referrals to areas such as social care, physiotherapy and dieticians were discussed and highlighted on the electronic boards. The boards then remained red until the referral had taken place and a plan put in place.
- Medical wards had access to pharmacy services seven days a week with out of hours cover provided by an on-call pharmacist.

Access to information

- We saw an electronic board system, which displayed patient information and allowed quick and easy access for all staff. The board allowed easy referrals to be made and the information was up to date so staff could assess each patient's needs in real time. The system made discharging and transfer of patients efficient.
- Patient's specific needs were also displayed in different colours to allow staff to see instantly if someone was diabetic or on a special diet and their level of vulnerability.
- Staff at all levels had access to the hospital's guidelines, policies and procedures through the internet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw good examples of Mental Capacity Act (MCA) and Depravation of Liberties (DoLs) assessments being completed particularly on the elderly care ward.

Medical care (including older people's care)

- We saw leaflets and information for staff that explained DoLS and were available. Staff told us that a nurse could be contacted, for specialist advice. Staff demonstrated how they accessed MCA DoLs and safeguarding policies through the trusts intranet.
- Staff on the elderly ward had a good understanding of MCS and DoLS and could give examples of when they had needed them in order to safeguard a patient. However, we could not see from the data provided whether staff were fully trained in this area.

Are medical care services caring?

Good

We rated caring as good because:

- Patients told us that staff cared for them well with compassion and kindness.
- We saw examples of good care being given on every ward we visited.
- The NHS Friends and Family Test (FFT) results from August 2015 to September 2016 showed 90% of patients would recommend the services.
- We saw that patients were included in decisions about their care. One patient told us that he had not wanted general anaesthetic for a procedure on his hand. Staff had discussed the options with them and a local anaesthetic was used instead.

Compassionate care

- Overall, we observed staff respected patients' privacy and dignity; they used curtains to ensure privacy and blankets to maintain dignity when carrying out personal care. However, we saw that a curtain had not been fully drawn in one bay. Staff rectified this as soon as it was pointed out to them.
- We saw a nurse dealing with an elderly patient in a kind and understanding way. The nurse explained things to the patient and was talking about their family, which was reassuring.
- The NHS Friends and Family Test (FFT) results from September 2015 to August 2016 showed a response rate of 29%, which is above average. Data showed that 90% of patients would recommend the service. Ward 17 had a 100% recommendation rate on the latest FFT results.
- We saw several compliment cards and letters from grateful patients and relatives. Staff were proud of the care they provided and a nurse told us "it's what I would like to receive".

Understanding and involvement of patients and those close to them

- Patients described the care as "excellent", "very good" and "great". One stated that he had not met anyone that did not care about them.
- Patients and their family told us that they were included in any decisions and treated as part of the care process.
- One patient told us that he had not wanted general anaesthetic for a procedure on his hand. Staff had discussed the options with them and a local anaesthetic was used instead. The patient was complimentary about the way he was listened to by the staff.
- We saw good care on ward 16 where a nurse was sitting between a patient and their partner holding both of their hands whilst talking to them.
- We observed a telephone conversation between a nurse and a relative, which was good. Information was given in a way that did not use medical terms and the nurse asked if there were any questions or messages that they wanted passing to the patient.

Emotional support

- Relatives of distressed or confused patients were able to attend the wards at flexible times to assist with the care and support of the patient.
- We saw good facilities for support for multi faith worship and there were a variety of faith leaders available for patients to access. Services were available at traditional times and we saw a person using the multi faith during our visit.
- Faith leaders could assist in supporting patients that received bad news or needed extra emotional support. Staff told us how they were able to contact someone if required.

Are medical care services responsive?

Good

We rated responsive as good because:

Medical care (including older people's care)

- Referral to treatment times (RTT) within 18 weeks was 95.6% between September 2015 and August 2016.
- We found the staff to be proactive in facilitating discharges and the process was improving with the introduction of a regular member of staff working in the discharge lounge.
- Stroke services had been reorganised to improve services
- There was a dementia friendly room (butterfly room) being developed on the elderly care ward with specific decorations to create a calmer environment.
- The hospital has set up a dementia café on ward 15 that was open to patients, carers and members of the public, offering support and awareness of dementia.
- We were told about an electronic system for predicting the level of admissions, based on a comparison from the previous six weeks admissions.
- We saw the notes for a patient that was classed as an outlier and found them to be completed and described a plan to support them whilst on another ward. Communication was good between the ward staff and the medical team.

However:

- Staff told us that sometimes patients were brought to the ward before a bed was available and they would have to wait in a bay. We were told this is due to the problem of delayed discharges from the ward and it could cause congestion.

Service planning and delivery to meet the needs of local people

- Stroke services had been reorganised to the one site at Telford, which improved the strength of the team and made coordinating the service better. Staff told us that they were able to provide a better service for stroke patients.
- The hospital has set up a dementia café on ward 15 that was open to patients, carers and members of the public, offering support and awareness of dementia. The Precious Times café is the latest initiative by the trust to improve care for patients living with dementia.
- We saw a flexible approach to visiting times for patients with dementia or other vulnerabilities. Family members could arrange to visit at any time to support patients and discuss care arrangements.

Access and flow

- The trust met the NHS 18-week referral to treatment (RTT) time and all medical specialities performed better than the England average from June 2015 to May 2016. The latest figures for August 2016 showed staff treated 100% of patients within 18 weeks in dermatology, gastroenterology and thoracic medicine.
- We reviewed patients classed as outliers, which are medical patients that are located in other areas such as on a surgical ward, to find out if they had the right level of care. Doctors described the process and explained that it had improved since being highlighted previously. We saw the notes for a patient that was classed as an outlier and found them to be completed and described a plan to support them whilst on another ward. Communication was good between the ward staff and the medical team.
- Average length of stay for elective patients, between April 2015 and March 2016 was 2.3 days. For non-elective procedures it was 5.8 in the same period, both were better than the average for England.
- Ward 11 was set up temporarily to help with winter pressures causing a higher number of admissions during the period between October and March. The ward is staffed by redeployment from other wards within the hospital so that agency staff are not used to manage the ward. In 2016, the trust introduced an enhanced ambulatory emergency care model across the trust. The aim of this was to reduce the number of patients needing an emergency admission by providing a medical day case-type service. This service provide care for older patients who require a short stay in hospital due to symptoms associated with frailty such as falls, dehydration, immobility and delirium. This process was designed to stop patients being admitted to a ward by treating them and returning them home.
- Due to high demand for medical beds, there were medical patients in surgical beds across the hospital. The trust had implemented a buddy system to ensure staff did not miss these medical outliers on surgical wards. This is where an assigned medical wards looks after outlining patients on another ward until an appropriate bed becomes available, although we were told that the surgical assessment unit at RSH did not have a buddy.
- We reviewed the patient records of four patients classed as outliers. We found that one patient had not been seen for three days as staff admitted them on Friday and the consultant had not been to see them over the

weekend. Staff on the unit were aware of this and told us this was not unusual for patients who were admitted over weekends to not be seen. The number of medical outliers trust wide between June 2016 and December 2016 ranged from 1459 to 1799.

- We visited the discharge lounge several times during inspection. We spoke to 13 patients all of which had been waiting for over an hour. Four had been waiting over 4 hours and one 6 hours. Staff told us that the main issue was waiting for medication, but a system was now in place where a member of the pharmacy team delivered the medications to speed up the process. The patient waiting over six hours was waiting for a family member to collect them.
- We found the staff to be proactive in facilitating discharges and the process was improving with the introduction of a regular member of staff working in the discharge lounge.
- Staff told us that sometimes patients were brought to the ward before a bed was available and they would have to wait in a bay. We were told this is due to the problem of delayed discharges from the ward and it could cause congestion. However, we were told that the introduction of the discharge lounge had improved this problem over time.
- We were told about an electronic system for predicting the level of admissions, based on a comparison from the previous six weeks admissions. This would enable bed management to be as effective as possible by predicting where the problems may arise.

Meeting people's individual needs

- Ward managers allowed flexible visiting hours to meet the specific needs of some patients. For example, people living with dementia, learning disabilities or patients who were particularly anxious.
- The hospital had access to an interpreter service if needed for patients whose first language was not English. Staff explained how to access the service and told us that it was good, but not used often.
- The Butterfly Scheme was introduced in 2014 to allow people with memory impairment to make their needs clear to staff and improve personalised care during their stay in hospital. It also acts as a reminder to staff of how to communicate with people living with dementia, including their families and carers in the process
- We saw a room on the elderly care ward that had been decorated in a style more suited for patients living with dementia. The room contained a television, radio and some games and puzzles, but was locked when we visited and staff told us it was only used once or twice a week. There was no call button in the room and it was located at the end of the ward away from toilet facilities.
- Wards were accessible by wheelchair users and disabled toilets were available in wards and public areas.
- Three NHS trusts from Shropshire had joined together in a bid to ensure patients got a good night's sleep in hospital. The trust came up with the 'Quiet Night – Sleep Tight' charter, which listed ways in which staff could make a difference. The trust also developed sleep packs for patients who were having trouble sleeping, which contained ear plugs and an eye mask to aid a restful night. These were available to patients on medical wards at RSH.
- Carer's passports were given to families and carers of vulnerable patients. This gave them the opportunity to visit outside of usual visiting hours to provide their knowledge of the patient to support the delivery of care to them in the most effective way.
- The trust ran one and two day dementia awareness courses which many medical staff told us they had attended. Dementia awareness was part of the staff induction process.
- Staff told us about the on-going promotion of the carers passport and the "This is Me" document improved care for patients with dementia and their carers by focusing on personalised assessment and care plans. Staff provided patient passports to patients living with dementia. This provided information about patients so that staff knew more about them such as their likes and dislikes and hobbies.
- Volunteers from agencies such as the women's institute knitted twiddle muffs. Twiddle muffs are cosy, knitted tubes of wool into which patients can put their hands as they rest them on their laps. Attached to the inside and outside of the muff are buttons, ribbons, beads, keys etc, designed to encourage patients to keep their hands busy, and to help stimulate their mind.
- A learning disabilities nurse specialist supported patients with a learning disability diagnosis.

Learning from complaints and concerns

- The complaints procedure was clearly assessable on the trust's website and staff could explain the procedure to

patients. There were leaflets available with advice about making a complaint and Patient Advice and Liaison Service (PALS) contact details were visible on corridors outside of wards..

- Ward managers told us that if a complaint was raised on the ward they would try to deal with it as a priority, however PALS team would be told if they could not deal with the complaint immediately.
- Staff told us that complaints and learning from incidents were discussed through channels such as team meetings and newsletters, which could be viewed at handovers.

Are medical care services well-led?

Good

We rated well-led as good because:

- The trust embraced new methodologies such as the partnership with Virginia Mason Institute and have developed new initiatives as a result.
- At PRH there was good communication between wards and in particular there had been an improvement in communication between doctors and nurses.
- Staff were aware of and engaged with the trust values and felt supported by local managers.

However:

- Managers could not describe what was on their wards risk registers or how it linked with the trust wide risk register.
- Staff told us that they did not see senior members of staff, above the level of matron, on the wards.
- Ward 11 had not had a team meeting since opening. Staff told us that continuity was a problem and we were not confident that staff could get information or lessons learned from incidents.

Leadership of service

- The medical care service had an assistant chief operating officer, medical director and head of nursing that managed the teams of medical and nursing staff. They linked to the executive team for the trust and had oversight of both hospitals in the trust.
- Staff told us they felt supported by the ward managers and matrons. We saw good communication between matrons and ward managers, particularly around staffing issues.
- Staff could access trust policies and procedures for complaints on the intranet. We were shown the intranet and links to various types of trust policies.
- Managers demonstrated an understanding of the challenges to good quality care and were able to identify the actions needed to address them. For example, managers were aware of the staff shortages and the impact upon patient care
- A senior nurse was acting as ward manager, but could not access any system for the monitoring of information. They had difficulty in showing us incident, audit, staffing or complaint data for the ward.
- Staff told us that they felt supported by the local management teams and that information was shared about clinical issues.
- Staff told us that they did not see senior members of staff, above the level of matron, on the wards. They said communication from them was not as good as they wanted.

Vision and strategy for this service

- Staff completed a values based corporate induction programme though staff were not necessarily able to recite the trusts vision and values they told us they were committed to providing the best patient focused care at all times.
- We saw several pieces of information that had been shared by the chief executive that demonstrated support for all staff in being part of the trusts visions and to provide the best healthcare possible to the community.
- The trust vision and values were available to staff on the intranet. We saw a statement – Proud to CARE, make it HAPPEN, we value RESPECT and together we ACHIEVE, used on documentation and posters to share the message.

Governance, risk management and quality measurement

- There was a clear structure in place to allow information to be reviewed and discussed with local managers. All aspects of governance were reviewed and actions or next steps developed to enable improvements to

medical services. Action plans were put in place to improve care with good communication across the medical directorate. The newsletter was a good example that all staff could refer to.
- Ward managers attended monthly governance meetings where incidents and complaints were discussed and any lessons learned shared. We saw minutes from these meetings along with a newsletter that was circulated to inform staff.
- We saw that clinical audits and related action plans were completed across the medicine directorate. An example is discharge summary audit which identified issues with medication on discharge which led to an action where a consultant and head of pharmacy developed an improved discharge summary.
- We saw folders on wards that contained copies of governance meeting minutes and newsletters for staff to access. This information was available back to January 2016.
- Managers told us that ward meetings were the most effective way of sharing lessons learned and other important information. They told us that due to staff shortages or redeployment, meetings were often cancelled.
- Local managers could not always describe what was on their ward risk registers or how it linked with the trust wide risk register. For example, the elderly care ward identified a risk around the suitability of the location and the design of the area. Managers said they were not confident that the risks were dealt with in an effective manner.

Culture within the service

- Some staff told us that there was disengagement between staff at Telford hospital and those at Shrewsbury hospital. They said that better communication was required from senior staff at both sites. We were told that changes to services such as maternity services being moved, were being discussed but the information was not reaching the staff at ward level.
- At PRH there was good communication between wards and in particular there had been an improvement in communication between doctors and nurses. There was a sense of pride in the way that all staff cooperated to provide good care for patients.

Staff engagement

- The trust used staff meetings, newsletters, email, and the intranet to communicate important information to staff. Staff told us that ward meetings were not regular due to difficulty in getting the staff to attend.
- Ward 11 had not had a team meeting since opening. Staff told us that continuity was a problem and we were not confident that staff could get information or lessons learned from incidents. However, the manager had displayed the latest newsletter and asked staff to sign to say they had read it.
- Staff told us that local managers were supportive and that they felt listened to and were happy to raise concerns with them, but some staff said that they did not have understanding of the future changes to the trust. They spoke of there being two different hospitals instead of being one trust.

Public engagement

- We saw a plan for the opening of a dementia café that would allow families patients, carers and other members of the public to join staff in discussing and improving awareness of people living with dementia.
- We saw posters and newspaper articles celebrating the 10 anniversary of the stroke unit's success. The staff were proud to be part of the celebration of excellence and teamwork throughout this period.
- We saw information about FFT on notice boards and staff told us that they spoke to visitor about taking part in the survey.
- We saw a variety of thank you cards and messages displayed on wards. In particular there were several cards on ward 15, which complimented particular staff.

Innovation, improvement and sustainability

- The Virginia Mason Institute (VMI) designed and developed its systems to become widely regarded as one of the safest hospitals in the world. The trust embraced these methodologies and in partnership with VMI, they have developed new initiatives within the hospital. They used the model to create the transforming care institute (TCI). TCI wants an effective approach to transforming healthcare by coaching teams and facilitating continuous improvement within the care system. The methodology used was underpinned by four main principles; leadership, training, facilitation and partnership.

Medical care (including older people's care)

- The trust was working to improve care for patients who suffered from sepsis and were using techniques developed from the VMI project to guide the process and produce a sepsis pathway.

Surgery

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

Information about the service

The surgery service at Princess Royal Hospital (PRH) provides specialisms including Head and Neck (ENT), trauma and elective orthopaedics and day surgery. Between October 2015 and November 2016 the hospital had 46,560 emergency and elective admissions and 27,486 operations were performed. There were 14,737 day surgery cases during this timeframe.

The Head and Neck ward has 14 beds. There are two six bed bays, a one bedded side room and an intermediate care area with one bed that could be used for patients who had undergone breast reconstruction surgery. Trauma and Orthopaedics usually has a total of 56 beds; split across two wards, one of which was situated within the day surgery unit at the time of the inspection, to help with winter pressures. There are 24 day case beds situated in the day surgery unit, as 16 of these were used for Trauma and Orthopaedics there were only 8 beds for day case patients in use at the time of the inspection.

We last inspected this service in 2014. It was rated as requires improvement in all areas except caring which was rated as good.

We inspected theatres and recovery, two wards and the day surgery unit. During the inspection we spoke with 45 staff members, 12 patients and their family members and three patient representatives. We also observed care and reviewed 13 sets of patient records.

Summary of findings

We saw and staff told us that information was not always documented appropriately therefore it was at time unclear whether risk assessments or other processes had been followed and what the outcome of these were. There was no use of an acuity tool to ensure that staffing levels met the needs of patients.

Ward staff showed a lack of understanding about their role with assessing patient's capacity to consent. We saw that medicines and intravenous fluids were left insecurely in theatres. Some patients reported delays of up to three hours in the receipt of pain relief whilst on the wards.

The service was consistently not meeting the Referral to Treatment Time target of 90%. The 2016 Hip Fracture Audit highlighted that 61% of patients with a hip fracture received surgery on the day or day after admission. This was worse than the national standard of 85%.

Staff were unaware of the trust vision and strategy and what their role in working towards this was. Staff did not feel the executive team were visible or had an understanding of the issues facing them and did not feel involved with future plans for the service. There were no ward meetings so staff did not have the opportunity to receive full updates or information about current issues.

However, staff treated patients in a caring and compassionate manner, they felt supported by their immediate line managers and that there was a positive

culture at the hospital. There were effective tools and processes in place to meet patient's individual needs including learning disabilities and dementia. Systems were in place and staff were clear of the protocols for assessing patient risks and managing deteriorating patients and there was a positive incident reporting culture. Evidence based care was provided and care pathways were based on relevant and current guidance.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- We saw that medicines and intravenous fluids were left insecurely in theatres and could have potentially been tampered with or removed.
- We found that not all recovery nurses or operating department staff were trained to ALS level. Attempts were made to ensure that a ALS trained member of staff was available on each shift. To mitigate the risk we observed that the anaesthetist did remain in theatres whilst the patient was in recovery.
- We saw and staff told us that information was not always documented appropriately therefore it was at times unclear whether risk assessments or other processes had been followed and what the outcome of these were.
- Care records were not kept up to date. Staff told us that on one ward, paperwork was routinely done after the staff finished their twelve hour shift. At times this resulted in some information being missed and unavailable during the day.
- Data provided by the trust showed that 71% of staff working within surgical wards and theatres at PRH had completed mandatory training at the time of the inspection. This was well below the trust target of 100%.
- Patient records were not kept securely and confidentiality could not be ensured.
- Staffing levels were not sufficient to meet the needs of patients on the wards. Although an establishment tool was in place, it did not take account of patients acuity.
- Current safety thermometer information was not displayed and staff were not aware of safety thermometer issues.
- Theatre storerooms did not have a cleaning schedule or checklist in place and some trolleys were seen to have dust on.
- Ward staff were unclear of their role in the event of a major incident and there was no plan in place for specific wards.
- There was inconsistent levels of understanding of the duty of candour, although staff told us they understood the importance of being open and honest.

However:

- Systems were in place and staff were clear of the protocols for assessing patient risks and managing deteriorating patients.
- There was a positive incident reporting culture where staff were encouraged to report and learn from incidents.
- We saw good practice in regards to infection prevention and control and there had been zero infections reported during the twelve months prior to the inspection.
- The day surgery unit provided each patient with an individual blood pressure cuff to minimise the risk of infection.
- The World Health Organisation checklist was embedded in theatres.

Incidents

- Between October 2015 and September 2016 the service reported two never events, both of which occurred within the head and neck department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- One of these never events related to the incorrect tooth being removed and the other a throat pack being retained. We saw the investigation reports that showed appropriate investigation had taken place and action taken to prevent this from happening again. During the inspection we spoke with staff and saw the recommended actions were in place and that staff were aware of why these were required. In theatres we saw staff documented key information in regards to the procedure being conducted on a board so that it was visible and clear for all to refer to.
- In accordance with the Serious Incident Framework 2015 The trust reported a total of 16 serious incidents between October 2015 and September 2016. The most common type of incident reported were surgical or invasive procedures (eight incidents - 50%).
- Staff across the service were aware of what should be reported as an incident and told us they were encouraged to report incidents of all kinds. Several staff members told us that they did not always have time to report incidents and to do so would often require them to stay longer than their shift hours.
- Staff told us that they did receive feedback from incidents they had reported however, there was not always time to learn lessons from incidents across the service or between sites. If learning from an incident led to changes in practice the ward managers would put notices up to inform staff. We saw examples of this during the inspection.
- Theatre staff gave examples of changes that had occurred as the result of the never event in theatres and other incidents. These examples included using different coloured throat packs and using a count board when conducting the removal of teeth.
- During April 2016, there had been four incidents that all occurred on the same trauma and orthopaedics wards. Two of these were avoidable pressure sores and two avoidable patient falls. The ward manager told us that there had been investigations completed, the staff had reflected on practice and changes made to the assessment of patients admitted to the ward. There had been various training days focussed on issues such as documentation and falls and the team started to hold meetings throughout the day to check the issues ongoing. The staff on the ward felt there had been a vast improvement in the care of patients for these specific issues following this and the number of falls had significantly reduced.
- Governance meetings including mortality and morbidity meetings were conducted within the directorate and although managers told us they were not always able to attend due to time constraints, they would always receive minutes from the meetings which were reviewed and relevant information cascaded to staff.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Theatre and ward staff demonstrated inconsistent levels of understanding about the processes involved with the DoC. Some staff were unaware of this however they did

tell us that they would be open and honest with patients if things went wrong. Ward managers demonstrated good understanding of the DoC and gave examples of when this had been put into practice.

Safety thermometer

- The NHS Safety Thermometer was in use by the surgical directorate to record the prevalence of patient harms in the ward environment. This entailed monthly audits of the prevalence of avoidable harms such as pressure ulcers, venous thromboembolism (VTE), falls and catheter-related urinary tract infections. This provides immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- We saw that up to date information was not displayed on the ward notice boards; for example either October 2016 data was on display (previous month) or no date or data was displayed on all notice boards.
- Staff we spoke with on the wards did not demonstrate robust knowledge of the safety thermometer data, including the reason for this being collected, displayed and their individual ward performance. We requested safety thermometer data following the inspection that was forwarded to us on a trust wide basis. Specific ward data was not available.

Cleanliness, infection control and hygiene

- There had been no cases of **Methicillin-resistant Staphylococcus aureus (**MRSA) or Clostridium difficile (C. Diff) in the twelve months prior to the inspection. We saw that infection prevention audits were conducted on wards. These audits highlighted issues and recommended actions to take to minimise the risk of infection, for example restocking hand gel for patients and ensuring there was appropriate signage on doors where patients were isolate to ensure all staff were aware.
- Data for Surveillance of Surgical Infections (SSI) in NHS hospitals in England is collected to monitor infection rates post-surgery. Between July 2016 and September 2016 zero infections were reported following 49 abdominal hysterectomies, 53 neck of femur repairs, 37 total knee replacements and 64 total hip replacements at PRH.
- We saw that staff working on wards and in theatres worked in line with NICE guideline CG74 to prevent surgical site infections.
- We saw that staff worked in accordance with trust policies in regards to use of personal protective equipment (PPE) and complied with good practice in regards to hand hygiene including having arms 'bare below the elbow'. We did see one instance where a staff member had used sufficient PPE whilst treating a patient but took clothing contaminated with blood through the ward without it being placed in a protective bag, exposing other patients to potential risk.
- The day surgery unit had put into place a system where each patient was given a blood pressure cuff which remained with them for the duration of their stay rather than being shared between patients. Staff felt this was an improved way of limiting the risk of infection from these pieces of equipment.
- Theatres were generally clean and fit for purpose. However, in an anaesthetic room we saw that some dust had accumulated on the bottom of two trolleys. We saw there were no daily cleaning schedules in place to ensure that all areas of theatres had been cleaned.
- During the inspection we saw two boxes of biscuits and serviettes on the work surface adjacent to theatre equipment such as sterile trays and consumables. This was an infection risk and so we raised this with staff and they were relocated to the staff room.
- We saw all ward areas were cleaned throughout the inspection and saw cleaning schedules that were up to date and demonstrated that wards were cleaned daily.
- Patient-led assessments of the care environment (PLACE 2016) had been reported. These assessments give patients and the public a voice that can be heard in any discussion about local standards of care, in the drive to give people more influence over the way their local health and care services are run. Results of the entire trust showed cleanliness scored 99.6% above the England average of 98.1%.

Environment and equipment

- Staff told us they had sufficient equipment to deliver care and we saw that equipment on the wards was well maintained including up to date electrical testing for all equipment.
- Equipment we saw in theatres was complete, fit for purpose and appropriately maintained. We saw that the Association of Anaesthetics for Great Britain and Ireland (AAGBI) guidelines were available and used for checking equipment.

- We saw the use of disposable slide sheets allowed for appropriate manual handling of patients from the trolley to surgical table in theatres.
- We saw that on one ward emergency equipment that should be checked daily had not been checked for two days. On the head and neck ward there was "emergency kit for neck breathers" which was identified as being required for weekly checks. This had not been checked for twelve days. When staff were asked about why the equipment had not been checked we were told this had been overlooked due to prioritising direct patient care and that there had not been the time. The equipment was then checked whilst we were there and the equipment was in date. We saw on the unannounced inspection that this had since been checked every day.
- We saw that two laryngeal masks on the resuscitation trolley for paediatrics in theatres were out of date (one expired in July 2015 and one expired in July 2016). This was raised with staff and we were told that they were to stay on the trolley as there was no alternative available to replace them. We were informed that theatre staff would communicate this issue with the resuscitation team.
- We saw oxygen cylinders were left directly on the floor rather than being securely stored in the holders situated on the wall. Cylinders should be secured upright with a chain or strap in a cylinder cart to avoid combustion when knocked over. When this was raised with staff they told us the porters had left them there following a patient returning from theatre and they were then replaced in the holders. We also saw oxygen cylinders stored directly on the floor in theatres rather than being placed in appropriate holders.
- We saw that Control of Substances Hazardous to Health (COSHH) recommendations were not all followed in the day surgery unit. Storage of some items for example flammable items being stored in a cupboard marked as containing items that were inflammable.

Medicines

- We saw that medicines and intravenous fluids were stored securely on surgical wards. The clean utilities had keypad locks on the doors and within the room medicines were stored in locked cupboards or refrigerators.
- We saw record logs that demonstrated that controlled drugs were administered appropriately.
- Refrigerator temperatures were recorded daily and we saw they were within acceptable limits.
- We saw intravenous fluids were stored in a store room within the day surgery unit that had the door wedged open. Although there was no key pad in place there was a lock on the door and a document that indicated a key pad lock would be fitted to ensure it would be pharmacy compliant.
- We also saw in an unattended and unlocked medicine storage cupboard that there were some labelled syringes containing drugs ready to administer. This had the potential for someone to tamper with the drugs and errors to be made.
- There had been one incident of medication errors that required a full root cause analysis. This was originally raised as a serious incident but was downgraded based on level of harm. The trust informed us that the vast majority of medication errors were managed locally due to the result being low harm or no harm.
- Staff told us that patients received their medication in a timely manner, however, some patients told us they had been required to wait for medication such as pain relief on occasions. Staff told us there were times where there could be delays with patient discharges due to waiting for their medicines to take home.

Records

- Patient records were paper based with nursing and allied health professionals notes being recorded in separate files to medical staff notes. Some staff told us this could cause confusion when trying to ascertain all of the patient information.
- An electronic system was used for recording patient observations and indicated when further assessments were required. Staff told us this electronic system was reliable and did not usually create any issues.
- We saw thirteen sets of patient records which were legible and up to date. Patient records were kept on a trolley, that was unlockable, usually kept by the nurses station however we saw this moved around the ward and at times was left unattended. This meant that confidentiality could not be ensured.
- We saw that two falls risk assessments that had not been completed in patient records. We spoke with staff about this and they said that although there would always be an assessment conducted, this was not always documented. During our unannounced inspection we reviewed five patient records. All of the

patients had a documented falls risk assessment however two had not been redone as they should have been and two had not included falls prevention care bundle information as it should have done. We spoke with the ward sister who told us she would discuss this with staff.

- Five staff working on one ward told us they did not have the time to document all of the care and treatment delivered to patients. An example provided involved a patient who was discharged without being given insulin as the patient records had not been appropriately updated. The family were unaware until the patient became unwell and contacted the ward to gain information. Due to the lack of documentation there was confusion about the incident and therefore the family had raised concerns.
- Staff on one ward told us that documentation was routinely done at the end of a shift rather than throughout the day and so often information was missed as they were relying on memory to complete patient records.

Safeguarding

- Staff we spoke with had completed online safeguarding training and were aware of what would constitute a safeguarding concern and how they should raise it. All staff we spoke with were aware of the trust safeguarding team and said they were well supported by them.
- Data provided showed 81% of staff working on surgical wards and in theatres had completed adult safeguarding training. Against a target of 100%.
- Between October 2015 and September 2016 there had been three referrals instigated by the surgery department at PRH (none of these were paediatric).

Mandatory training

- The trust had a mandatory training programme in place. This included topics such as basic life support, infection control and manual handling.
- Data provided by the trust showed that 71% of staff working within surgical wards and theatres at PRH had completed mandatory training at the time of the inspection. This was well below the trust target of 100%.
- The level of completion varied between departments as although 89% of staff working on the head and neck and trauma and orthopaedic wards had completed this training, only 50% of medical staff working in trauma and orthopaedics had done so.

Assessing and responding to patient risk

- Staff used the World Health Organisation (WHO) 'five steps to safer surgery' checklist to ensure required pre and post-operative safety checks were undertaken. A "How to" guide was displayed and information available outlining each staff members responsibility as part of this. We observed this process five times during the inspection and saw that it was embedded and working effectively at the time of the inspection with specific patient risks discussed prior to each procedure. The trust conducted a monthly audit of the WHO checklist which showed high levels of compliance, for example in September 2016 compliance was 100% for 86 patients, however this was based upon audit of documentation rather than actual observation. The trust did not conduct observational audits.
- We saw staff followed Association for Perioperative Practice (AfPP) recommendations for safe practice (2016) by visually and verbally confirming swab and instrument count between practitioners. This was recorded, along with patient information, on a white board as per the AfPP best practice guidelines.
- We saw staff check patient pressure areas prior to transfer from the trolley to surgical table in theatre.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) state that at all times there should always be at least one member of staff present who is Advanced Life Support (ALS) trained. An anaesthetist should always be available to attend immediately; who will provide further ALS trained 'cover' for emergencies in the recovery area. However, the anaesthetist does not require being physically present at all times. At the hospital, we found that not all recovery nurses or operating department staff were trained to ALS level. Attempts were made to ensure that a ALS trained member of staff was available on each shift. To mitigate the risk we observed that the anaesthetist did remain in theatres whilst the patient was in recovery.
- During observations and from review of patient records we saw that staff used an electronic patient observation recording system. This followed the Modified Early Warning Score (MEWS) system and provided an automated calculation at the patient's bedside. MEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to surgical ward patients. The primary purpose is to prevent delay in intervention or transfer of critically

ill patients. If a patient's deterioration was detected, staff would follow the escalation protocol to provide the appropriate response for the patient and staff told us this process worked effectively.
- Staff were aware of protocols for managing deteriorating patients and gave examples of when they had received support from staff from the high dependency unit. Staff told us this worked well however due to staffing levels and bed capacity issues there were times when they felt that other patients may be left unsafe whilst an emergency was being dealt with.
- Staff told us there was sufficient levels of support provided by the intensive care outreach team when required.
- On the trauma and orthopaedic ward, staff participated in regular safety briefings that occurred numerous times throughout the day. They discussed risk of falls, infection control, bed capacity issues and other relevant patient safety information.
- On the Head and Neck ward there was a treatment room that was also used as an overnight side room for patients when required. There was a risk assessment in place for this that clearly stated that this should be used for low acuity patients only. Staff told us this was often used for patients who were not assessed as being low acuity (sometimes medical outlier patients) and they did not feel it was safe as, due to requirements of staff working with patients on the rest of the ward, they were unable to appropriately observe these patients. Staff told us they had escalated their concerns and we spoke with the Matron who confirmed that she was aware of the issues staff faced with this. An audit of the use of the treatment room had been conducted but there had been no changes in the use of it as a result of this and it had not been conducted in the twelve months prior to the inspection.
- We saw patients wore "red alert" wrist bands when a known allergy had been identified.

Nursing staffing

- Ward managers told us that there was a 'staffing establishment tool' used which was completed monthly, based on the required staffing levels for the previous month. Staff told us that although the planned staffing levels were usually achieved this did not seem adequate for the acuity of the patients usually admitted to the wards. These were not displayed on the wards during the inspection. The establishment tool did not take into account the acuity or needs of the patients on the wards at that time.
- We reviewed rotas and saw during the inspection that planned staffing levels were usually maintained. Staff told us this there was regular use of agency staff to cover staff sickness and maternity cover.
- During our inspection we observed that the planned staffing levels were being met but the number of staff on duty was inadequate for them to complete all of their necessary duties within their shift and patients were subject to delays in care or some needs were not being met. We escalated our concerns to the Matron of the day who arranged for an additional nurse to assist from another ward.
- We saw nursing staff handovers that took place at the start of each shift at the patient bedside. There were also some handover discussions that took place at the nursing station. We observed a handover and saw that the essential information was given for the patient's safety and that staff were checking details they would be required to follow up during the next shift.
- We saw an agency nurse was given an induction to the ward including information about where to find necessary equipment. Staff told us this induction always took place.
- We saw and staff told us that nurses and healthcare assistants on wards could go for long periods of time without having a break. They told us this was a regular occurrence depending on the patient needs they may not have a break at all during their twelve hour shift. Staff told us they did not always report this issue as an incident as submitting the paperwork would result in their shift being even longer.
- There were seven vacancies for theatre staff at the time of the inspection; agency staff were booked to fill these positions.
- There was a visible staffing board on display that showed all theatres were staffed in line with AFPP recommendations for safe staffing. The theatre manager confirmed that this was the minimum planned staffing for theatres. Agency staff were documented in red pen to identify them and the staffing was reviewed to ensure only one agency staff member was in place for each team.

Surgery

- We saw and staff told us that two paediatric nurses were on shift in theatres for all children's surgery planned which staff felt provided sufficient support.

Surgical staffing

- There were on call arrangements in place for surgeons at PRH to specifically cover emergencies for Head and Neck, Trauma and Orthopaedics and paediatrics.
- There was a consultant general surgeon on site at PRH during daytime hours Monday to Friday which was provided as part of the general surgical emergency rota at RSH. If general surgical problems presented out of hours the patient would be seen by the speciality middle grade doctors based at PRH who would refer to the general surgical consultant on call at RSH when appropriate. We saw that this was satisfactory for meeting the needs of patients who may require this care.
- Staff reported that the use of locum doctors was high. We did not receive data to show the levels of locum use. Senior staff told us they were currently reviewing the use of locum staff.
- We saw the daily ward round carried out by medical staff, who told us they saw all new patients as well as those with fractured neck of femur or any other complex cases every day. The nurse in charge of each ward also attended the medical ward round to receive or provide information regarding each patient.
- Medical handovers took place at the start of each shift and at the end of 'on call' shifts.
- Junior doctors we spoke with told us they felt supported by the senior medical team. Medical staff attended wards seven days a week and daily consultant rounds took place.

Major incident awareness and training

- There was a trust major incident plan in place which, stated that each area should have its own outline plan. We saw the overall plan however the wards did not have any specific protocol in place for staff to follow in the event of a major incident and it was therefore were unclear of what their specific role would be. Staff working on wards and in theatres told us they had not had any training in regards to major incidents and were unaware of the plan.
- Emergency plans and evacuation procedures were in place.

Are surgery services effective?

Good

We rated effective as good because:

- We saw evidence based care was provided and care pathways were based on relevant and current guidance.
- Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016 indicated that for patients who had undergone a hip or knee replacements outcomes were better than the England average.
- The average length of stay for was 14.8 days which falls in the best 25% of trusts.
- Patients were provided with information about pain relief prior to surgery and their pain levels were checked and documented regularly throughout their stay.
- We spoke with new staff and agency staff who confirmed that a full induction was provided.
- There was evidence of good multidisciplinary team working on the wards we inspected. Staff told us that this approach was part of the culture of the trust.
- We saw that patient's nutritional requirements were met and appropriate support and processes followed when necessary.

However:

- Ward staff showed a lack of understanding about their role with assessing patient's capacity to consent and what the protocol was for medical staff involvement and at what stage an assessment should take place. We saw examples where the documentation had not been completed appropriately.
- Patients reported delays in the receipt of pain relief whilst on the wards.
- The perioperative surgical assessment rate was 64.7% across the trust which does not meet the national standard of 100%.
- We saw from patient records that care pathways were not documented for patients with tracheostomy.

Evidence-based care and treatment

- We saw that relevant and current evidence-based guidance was followed with care pathways in place for example management of fractured neck of femur and sepsis.

Surgery

- We saw from patient records that care pathways were not documented for patients with tracheostomy. Staff told us they did not usually do so however care pathways were in place and staff were aware of these.
- We saw NICE guidance in use on the wards for example NICE CG50, a guideline for care of the deteriorating patient and how they should be cared for when this happens was used.
- We saw evidence that staff adhered to local policies and procedures such as not operating routinely during the evening.
- Association of Anaesthetics for Great Britain and Ireland (AAGBI) safety guidelines were available.
- Difficult Airway Society (DAS) guidelines were available for staff to follow in the event of failed intubation of patients or other airway complications.
- We saw minutes of Centre Operational Governance meetings where new or updates to national/local guidelines were discussed.
- We saw that patient's had their needs regularly assessed and their care was planned and delivered in line with evidence-based guidance and best practice. We saw and staff told us that this was not always documented due to time pressures.

Pain relief

- Patients were provided with information about pain relief during the pre-op assessment.
- We saw that patients were asked about their pain following surgery and staff used a pain scale of one to 10 to help patients describe the level of pain they were experiencing. Pain charts were documented when pain relief had been administered.
- We spoke with two patients who told us that despite requesting pain relief and feeling considerably uncomfortable, they had been required to wait for up to three hours to be provided with this. When we discussed this with staff they told us that although they felt this was very important, they were required to prioritise patient safety and this had led to them being too busy to administer the medication in a more timely manner. We spoke with a further 10 patients who were satisfied with the pain relief provided.

Nutrition and hydration

- We saw a trolley available on each of the wards for patients to provide themselves with drinks throughout the day. We also saw healthcare assistants conducted comfort rounds and providing patients with food and drinks.
- Meals were served during protected visiting times. We saw patients who required assistance to eat and drink were supported by staff.
- Intravenous fluids were prescribed and administered when diet and fluids were restricted.
- We saw patients who required changes to their type of diet post-surgery such as soft food were given support and assistance from the nursing staff and dieticians. This information was recorded in patient records.
- Nutritional assessments were conducted for some patients and intake was recorded.
- Patients told us they were satisfied with the choice of food available and that it met their dietary requirements. We spoke with a patient experience representative who said that the feedback about food choice was good and catered for a range of requirements including cultural needs but they told us there seemed to be a lack of options for those requiring a gluten free diet.

Patient outcomes

- Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016 indicated that for patients who had undergone a hip replacement, 83% reported improvement following the procedure which was better than the England average of 82%. Patients reporting worsening of symptoms following surgery was 9% which was better than the England average of 11%. Following knee replacements, 78% of patients reported improvement which was better than the England average of 75%. Patients reporting worsening of symptoms was 14% which was better than the England average of 15%.
- The 2016 hip fracture audit for PRH highlighted that 61% of patients with a hip fracture received surgery on the day or day after admission. This was worse than the national standard of 85%. This audit also showed that the average length of stay was 14.8 days which put the hospital into the top 25% of trusts.
- The 2016 hip fracture audit highlighted that across the trust, the proportion of patients not developing pressure ulcers was 65.7% which fell in the middle 50% of trusts.

- The proportion of patients having surgery on the day of or day after admission was 61%, which does not meet the national standard of 85%. The perioperative surgical assessment rate was 65%, which does not meet the national standard of 100%. The proportion of patients not developing pressure ulcers was 66%, which falls in the middle 50% of trusts.
- The perioperative surgical assessment rate was 64.7% across the trust which does not meet the national standard of 100%.
- The average length of stay for was 14.8 days which falls in the best 25% of trusts.

Competent staff

- The nursing and medical staff we spoke with told us that although they were supported and encouraged to participate in training opportunities, it was difficult to do so with the time provided due to the pressures of theatres and wards.
- We spoke with new staff nurses on the wards who told us the induction period had been very comprehensive and that all mandatory training was included and completed. There was a supernumerary period of six weeks which they felt was satisfactory and they told us that the teams were supportive of their development so far.
- All agency staff in theatres received a full induction prior to working in the department. We saw that new staff working in theatres were shown how to work with equipment and best practice was shared. We saw agency staff receiving induction on the wards and staff told us this was always done although they did not feel like there was enough time to go through more than the essential information.
- Some scrub practitioners were trained as Surgical First Assistants (SFAs) and staff confirmed that only those appropriately qualified would act in this role. We observed this to be the case during the inspection.
- Scrub practitioners only performed dual role duties for minor procedures in line with Perioperative Care Collaboration 2012 recommendations. We observed this to be the case during the inspection.
- Staff told us they were supported through the revalidation process and that they could gain information about this from the intranet and their managers. There was a 360 feedback process as part of this was currently being rolled out to staff. They told us they met with supervisors and matrons to go through their revalidation requirements and ensure they were prepared.
- Data provided by the trust showed that 88% of staff working on surgical wards and in theatres had completed an appraisal. Staff told us they found the appraisal process beneficial for their development and that these occurred annually.
- Staff discussed concerns about medical outlier patients being cared for on the wards. They told us that the needs of these patients were becoming more complex and they did not always feel competent to care for them safely.

Multidisciplinary working

- There was evidence of good multidisciplinary team working on the wards we inspected. Staff told us that this approach was part of the culture of the trust.
- Staff told us that they had good working relationships with a variety of healthcare professionals including physiotherapists, speech and language therapists and dieticians. Physiotherapists were visible on the wards and were part of the team.
- We reviewed eight patient records that demonstrated that care and treatment was provided by a variety of healthcare professionals including doctors, nurses, physiotherapists, pharmacists and dieticians.
- We also saw that there was input from the alcohol liaison team and staff told us they had good working relationships with this team.
- Staff told us that when appropriate they worked alongside the Macmillan team and the local hospice to provide effective joint care for patients who required these services.

Seven-day services

- Out of hours services were available including radiology and pharmacy services.
- We saw there were on call arrangements for doctors overnight and at weekends to cover emergencies. General surgical cover was available but the team was based at the Royal Shrewsbury Hospital and so patients would be seen by the speciality middle grade staff on site at PRH and would then refer to the on call general surgical consultant as appropriate.

- Staff told us there could be delays when obtaining support from medical staff out of hours for example to set up intravenous lines for patients with low blood pressure.
- Physiotherapy services were available at weekends for patients who required it, this was a more limited service compared to the weekdays however provision was available.

Access to information

- Staff were able to access guidance and protocols through the trust intranet.
- Patient records were paper based with nursing and medical notes recorded in separate files. Staff told us this could cause confusion when trying to ascertain all of the patient information although some staff also said it could be helpful for them to be separate for clarity of the different input.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw and patients told us that they were asked permission prior to care being provided.
- We saw consent forms that were signed and dated prior to surgical procedures being conducted.
- Senior staff demonstrated good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw that there were good templates to follow for assessment of capacity and that there was a reference card available for staff with a five point assessment tool. There was a contact number displayed for staff to gain further information when necessary.
- Ward staff showed a lack of understanding about their role with assessing capacity and what the protocol was for medical staff involvement and at what stage an assessment should take place. Staff told us they had not completed any recent training on this topic. We saw an example of a patient who required assessment for capacity however, the relevant paperwork had not been completed for over 24-hours as staff on the ward were waiting for a Doctor to complete this.
- We saw another example of a patient who did not have capacity to consent and the documentation was detailed and clear. We saw that Enhanced Patient Support (EPS) was in place however, the best interest decision form that should have followed for this had not been completed.

Are surgery services caring?

Good

We rated caring as good because:

- We saw that staff treated patients in a compassionate manner.
- Patients told us they had felt fully informed throughout their experience and had good understanding of their treatment as a result.
- The surgery services participated in the Friends and Family test. Results from this were positive as they showed that over 85% of those who participated would recommend the service.
- We saw and patients told us that staff provided good quality emotional support to them when required.

However:

- We saw some examples of staff not closing curtains around patient beds at times where privacy was then compromised.

Compassionate care

- During the inspection we saw that staff treated patients with compassion and respect.
- We saw that privacy and dignity was maintained when staff provided personal care by closing the curtains. However, we did see some examples of staff not closing curtains when interacting with patients at the bedside such as during handovers and ward rounds which meant information about their care and treatment was not always confidential.
- All of the patients we spoke with told us that they felt the staff treated them in a very caring manner although most also commented that the staff were very busy and so felt like discussions were often rushed.
- Staff on one ward told us they did not always feel they had the time to provide the care they would like to for patients and often felt hurried and only able to provide the necessary treatment rather than any additional care.
- The trust participated in the NHS Friends and Family Test. The response rate for surgery at PRH was 27% between September 2015 and August 2016 with the percentage of respondents that would recommend the service being consistently above 85%.

Surgery

Understanding and involvement of patients and those close to them

- Patients told us they had felt involved and were given the opportunity to ask questions and were given sufficient answers or information during their pre-operative assessment.
- We spoke with patients who had undergone surgery. They told us they had been given details about the operation and what they should expect post-surgery.
- We saw that an anaesthetic practitioner introduced themselves to the patient and clearly explained what would happen in the anaesthetic room.
- One patient told us she had been kept fully informed all the way through the process and had found the consultant to be extremely helpful with answering all of their queries.

Emotional support

- The patients we spoke with spoke highly of the emotional support staff had provided when they required this. One patient told us "the staff are very friendly and reassured me at all times".
- Discussions relating to anxiety and depression were discussed on admission. The staff we spoke with told us they contacted the consultant when a patient showed extreme anxiety prior to surgery to ensure they met with the patient prior to the surgery. The staff told us they gave the patient time to discuss their concerns and answered their questions to allay their fears. Patients we spoke with told us that the staff were very good at reducing their pre-operative nerves.
- Thank you cards displayed included comments such as "each and every one of you has given me the up most care and attention, nothing has been too much trouble."
- During the inspection staff were aware of a patient who would be receiving bad news about their diagnosis. The ward sister spoke with a family member and asked them to attend the ward to discuss in person and then told us that a side room would be used to give the family time together.
- Staff told us counselling services were available for patients who required this and were able to locate the details in order to be able to refer when necessary.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The trust were consistently not achieving the Referral to Treatment Time (RTT) indicator of 90%.
- Staff were concerned about the pressures to discharge patients to ensure there was bed availability for those patients who had undergone surgery.
- The 2016 hip fracture audit for PRH highlighted that 61% of patients with a hip fracture received surgery on the day or day after admission. This was worse than the national standard of 85%.
- Staff told us they did not receive feedback from complaints across the trust and so the opportunity to learn from these was missed.

However:

- The 2016 hip fracture audit showed that the average length of stay was 14.8 days which put the hospital into the top 25% of trusts.
- There were effective tools and processes in place to meet patient's individual needs including learning disabilities and dementia.
- Staff were aware of the process for patients to follow to raise concerns and gave examples of changes in practice as a result of complaints.

Service planning and delivery to meet the needs of local people

- Theatres were available between 8am and 6pm Monday to Friday. One team worked late until 8:30pm for trauma cases and were then on-call overnight to cover emergencies. At weekends, one theatre ran from 8am to 5:30pm and then one team was on-call overnight for emergency cover. As there was no dedicated trauma theatre at weekends, this one emergency theatre was required to cover all specialities. We had concerns that this may impact upon the timeframe patients with fractured neck of femur received their treatment as other more urgent cases would take priority and requested data from the trust but none was provided.

- The average length of stay for surgical elective patients at PRH was 2.3 days which was lower than the England average of 3.3 days; for surgical non-elective patients, it was five days which was slightly lower than the England average of 5.1 days.
- There were ongoing discussions for the trust to possibly reconfigure the services for surgical services as part of the 'future fit' plan.
- We saw that changes had been made to services to manage the demand for services over the winter which included the transfer of patients from the trauma and orthopaedic service to the Day Surgery Unit.
- To meet the needs of patients there were arrangements in place for a local private hospital in Shrewsbury to provide support for surgery. At the time of the inspection this hospital had provided treatment for eight patients in the previous two weeks. The agreement covered provision for the private hospital to conduct procedures for up to 50 patients covering the two months following the inspection.

Access and flow

- There were 14 beds on the Head and Neck ward and a total of 56 beds for trauma and orthopaedics. Between October 2015 and November 2016 there were 27,486 operations performed at PRH.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery was lower than the England overall performance between September 2015 and August 2016. The figures for August 2016 showed 73.8% of this group of patients were treated within 18 weeks. The trust was therefore not meeting the treatment indicator of 90%.
- For oral surgery 37.1% of patients were treated within 18 weeks compared to the England average of 73.5%. For trauma and orthopaedics 47.7% of patients were treated within 18 weeks compared to the England average of 68.5%.
- NHS England data showed that for the period July 2015 to July 2016 the trust cancelled 1163 surgeries. Of these, 0.9% were not treated within 28 days. We spoke with a patient who had had their surgery cancelled twice in June and October 2016. The patient told us that they had received plenty of notice about the cancellation and did feel fully informed about the arrangements for rescheduling it.
- Bed occupancy at the trust between April 2016 and September 2016 was 92.3% which was higher than the national average. The accepted level at which bed occupancy can start to affect the quality of care afforded to patients and the systematic running of a hospital is 85%.
- There were three site meetings per day to review the bed occupancy levels and communicate any issues across departments. The 'matron of the day' worked with the capacity manager to organise bed moves and patient discharges. Staff told us this seemed to work well as all areas could then work together to try to reduce cancellations of surgery although there remained pressure to discharge patients from the ward to allow the flow of more patients following surgery.
- During the inspection staff raised concerns with us about the admission of patients to surgical wards. This was because on a daily basis there were examples where patients would have surgery without a bed being available for them prior to going to theatre. Therefore, the bed availability post-surgery depended on other patients discharge arrangements. Staff told us that it put a lot of pressure on ward staff to ensure that the flow of patients met the requirements for those patients in theatre to have a place on their return from recovery. At times due to lack of space to wait on the ward, staff told us that patients would wait for surgery on a trolley in the corridor outside theatres.
- Staff told us that the treatment room on the head and neck ward was often used as an in-patient bedroom. This meant that at these times there was the lack of an area for patients to prepare for theatre and so would at times have their anti-embolism stockings put on in the corridor outside theatres. The staff we spoke with told us they tried to maintain privacy and dignity at all times and so would use screens however felt it was not satisfactory for patients.
- Due to shortages of beds in other areas of the hospital staff told us at times medical patients were admitted to the surgical wards. They told us this could impact upon elective surgical patients due to the lack of beds available.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-surgery.
- Between October 2015 and November 2016 no overnight stays in theatre were reported.
- We saw from patient records and staff told us that there was multidisciplinary input with discharge planning. We spoke with two patients who had been discharged who

told us they felt this had been well planned in an organised manner. Staff told us that due to some complaints raised about lack of communication at the discharge stage, changes to processes had taken place and improvements in how this was discussed with patients had been noticeable.
- At the point of discharge patients were provided with a discharge letter, their medication and advice leaflets.

Meeting people's individual needs

- Staff told us they were usually aware of patients with learning disabilities prior to being admitted to the ward. They told us suitable arrangements were put into place to meet the needs of patients and staff in all areas we visited were aware of these. Examples of this were allowing carers to remain on the ward with the patient and the use of illustrated flashcards to help with communication.
- Staff told us that for patients identified to be living with Dementia, the Butterfly scheme was in place to ensure their specific needs were met. For example, ensuring that they had the closest possible bed to the nurses station, preferably a side room. One to one nursing was put into place and an assessment would be completed to identify if any further support could be provided.
- 'Twiddlemuffs' are a knitted hand muff with attached items designed to provide a stimulation for patients with dementia. Staff told us these were requested from medical wards if it was felt they would benefit a patient.
- Staff on the head and neck ward cared for patients who may be unable to speak following treatment. We saw that patients were provided with pen and paper to assist with communication and they told us they found this to be helpful.
- Patient information leaflets about surgical procedures were available on the wards we visited. Staff told us that these could be provided in different languages or formats if required.
- Staff told us that translation services were available for patients whose first language was not English. Translators were booked to be present in person rather than using telephone services however, staff told us if they required a translator at short notice they had to use a telephone service.
- During the inspection we spoke with a patient who had requirements to have a bed located near to the patient toilet. The patient told us they had asked staff about this and had remained in a bed that was too far from the toilet to effectively meet her needs. The patient had called staff for assistance to get to the toilet however due to being required to wait and the distance to the toilet had experienced incontinence. We saw the patient was provided with a more suitable bed after raising issues with staff.
- Staff told us there was a Swan scheme in place for patients who were receiving end of life care and to support their relatives through this difficult time.
- Staff on the trauma and orthopaedics ward told us the toilets being a long walk from the female beds caused issues at times and did not always meet patient's needs.

Learning from complaints and concerns

- The surgery service at PRH had received 48 formal complaints during the period November 2015 to December 2016.
- There was a patient advice and liaison service (PALS) in place which was a team who would deal with patient concerns without the formal complaints procedure. We saw that there was a proactive approach to handling these concerns and that staff told us they felt this reduced the number of formal complaints submitted. Not all staff in theatres were aware of the PALS team.
- We saw that information about the PALS team and how to raise a concern were situation on wards and in corridors.
- Staff gave examples of concerns that were raised on the wards and described how they attempted to resolve issues at a local level. We saw staff do this during the inspection when a patient's relative raised concerns about the delay in staff administering pain relief.
- Staff told us they received feedback from complaints from the ward manager and that changes were put into place following review. Ward meetings were not taking place so complaints could not be discussed with the team in this format.
- Although staff told us they received feedback from complaints raised in the area they worked in, they did not receive information about concerns from the wider trust or services and so the opportunity to learn from these was missed.

Surgery

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff were unclear of the trust strategy and what their role in working towards this was. Staff were aware that there were likely to be changes to the structure of the service but did not feel involved with any ongoing plans.
- Staff working in theatres and wards were unaware of what issues were on the risk register or what action was being taken in regards to key risks.
- There were no ward meetings being conducted so staff did not have the opportunity to receive full updates or information about current issues.
- Staff did not feel the executive team were visible or had an understanding of the issues facing them working in theatres or the wards.
- There was a noticeable low morale on one ward that staff felt was the result of working over and above their working hours at an unsustainable pace on a consistent basis.

However:

- There was a risk register in place that contained key issues from the surgical department that was discussed at centre operations governance (COG) meetings.
- Staff felt supported and listened to by their immediate line managers and felt there was a positive culture working at the trust.
- Staff were aware of the trust values.

Leadership of service

- Surgical services were part of the Scheduled Care Group. The group included outpatients, surgery, oncology & haematology, cancer services, head, neck & ophthalmology, MSK and anaesthetics, theatres & critical care. Each speciality, or centre, had a clinical director, centre manager and matron. The Care Group was led in a triumvirate by an assistant chief operating officer, head of nursing and care group medical director.
- We saw good leadership on the wards. Staff told us they felt supported by and listened to by their immediate line managers and spoke highly of them. Ward leaders told us they felt supported by senior managers but were unsure if the senior leaders understood the day to day pressures. Staff told us they did not feel the executive team were visible or could easily take issues to them directly.
- Two of the ward managers had been nominated for awards a part of internal award events and also external awards.
- Staff told us that the system of having a 'matron of the day' and 'operations manager of the day' worked well and that it had resulted in less delays with decisions about care and patient flow being made.
- Although staff told us they could raise issues with their managers and they did feel these were escalated appropriately they also told us they did not always receive feedback or feel as though the executive team were aware of the issues they were having at ward level.

Vision and strategy for this service

- The trust values were displayed and staff were aware of what these were. The trust had a vision and strategy in place however, staff we spoke with were unaware of what these were or their role in achieving it.
- Staff told us they were empowered to raise concerns; however issues such as staff shortage and ward environment improvements were not addressed. Harm free care days were not displayed; we were told that when mistakes did happen the staff understood the importance of being open and honest.
- The current configuration of the specialities between two site was under discussion, reviewing sustainability in an attempt to provide the best service for the local communities. The future for the service was described uncertain by many staff due to many changes and lack of insight in to the day-to-day issues and poor information update from management.

Governance, risk management and quality measurement

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

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

- Quality and safety issues were discussed at centre operational governance meetings. Health care standards were also discussed at these meetings such as referral to treatment targets and cancellation of operations. First priority on the surgery risk register focussed on loss of accreditation status with failure to maintain Joint Accreditation Group (JAG) standards due to the inability to recruit a nurse endoscopist. Attendance at statutory and mandatory training was also on the risk register; a new venue for training and a programme review planned to increase compliance.
- The quality and safety committee chaired by Non-Executive Director and included two further Non-Executive Directors. The board of directors and executive level director groups received monthly performance reports on national and local targets.
- Staff working in theatres and on the wards were unaware of what issues were included on the risk register for their department. Their main concerns were focussed upon staffing shortages and the risks that were involved with caring for patients in a treatment room due to bed occupancy issues.
- Staff told us there were no ward meetings being held due to staff availability therefore key issues were not discussed in this format. Ward managers displayed key information in the office and staff told us they did have key information communicated verbally. However, it was apparent that information such as trust wide issues or audit results were not communicated on a regular basis with staff.
- Staff told us there was a 'governance day' held monthly. This was a monthly event where they could book training that covered governance issues. Staff told us they had attended but it could be difficult due to the requirements of staffing on the wards.

Culture within the service

- Many staff we spoke with had worked within the trust for a considerable number of years and told us they felt it was a good place to work. We also spoke with new staff members who also felt there was a positive culture within the trust and told us they had felt welcomed and supported. Staff told us there were pressures with managing good patient care with the current staffing levels and this led to staff feeling stressed, breaks were often missed and staff were tired.
- Staff told us they would feel comfortable in reporting their concerns to their immediate line manager or a senior staff member if appropriate. However, they did not feel confident that action would take place.
- There was an open culture in regards to incident reporting on the wards and we saw huddle meetings take place on a ward where near miss situations were discussed and reporting encouraged by the ward manager. Staff told us they felt that incident reporting was important for learning to take place.
- Within theatres, staff told us the culture had changed in regards to incident reporting as this was being more encouraged and a no blame culture becoming more embedded. A quicker system for raising incidents for theatre staff had been put into place and although there were mixed opinions of the effectiveness of this, it was clear that the team were being more proactive with recording incidents as they occurred.
- Staff consistently told us they were proud of the teams they worked within and that they were all hard working and supported each other.
- There was a notable difference in the morale of staff working on different wards. Those working on the trauma and orthopaedics wards and the day surgery unit told us that although they were busy and did feel pressure they felt their work was manageable and they enjoyed their roles. However the staff working on the Head and Neck ward felt there had been a lower morale level as pressure increased and the workload seemed to be increasing. Senior staff were aware of this and told us they were trying to provide staff from other areas to support the team as much as possible.

Public engagement

- The Patient Experience and Involvement Panel (PEIPs) brought together patients and carers to shape the plans for improving patient experience; improving the way the hospital gathered information about patient experience and to gain feedback directly from patients. We saw a member of the PEIP speaking with patients and staff on surgical wards during the inspection.
- If patients or visitors had a particular interest in hospital services, or if they had shared their experiences, good or

bad, the management encouraged them to contact the hospital to join appropriate initiatives and expert patient groups. This information was available on the hospital website.
- Patients and local people were encouraged to get involved in the hospital by becoming a member of the trust. The elected public governors had a powerful voice to represent the interests of communities in Shropshire, Telford & Wrekin and mid Wales. Members of the public could apply by visiting the 'Becoming a member' page on the hospital website.
- Trust wide approximately 800 volunteers gave their time to patients, visitors and relatives at both hospitals playing an important role working alongside staff in a variety of different departments.

Staff engagement

- Staff told us there had been a change with working hours which meant that nursing staff were working twelve hour shifts on the wards. They told us there had been little consultation about this and that they felt it was unsuitable for the type of work they were required to do. Staff told us they had raised their concerns however felt that they should have been consulted at the time the decision was made as they did not feel their objections to this now were having any impact.
- Staff told us they did not feel involved with future plans for the surgery department.
- The trust had an staff recognition awards system in place so that staff could nominate their colleagues when they felt this was deserved. Some staff members working on the surgical wards had been nominated and/or won awards.
- We saw that notice boards in staff areas had up to date newsletters containing updates on recent events and plans that were shared across both sites.

Innovation, improvement and sustainability

- Staff working on the Head and Neck ward told us they did not feel the current workload was sustainable and had concerns about the future of this service.
- The medical director sent out a 'Message of the Week' email to staff across the trust describing events of the week and inviting staff to reflect on their experiences.
- In April 2016, 33 managers across surgical services attended a 'managing budgets' masterclass to help them understand financial terminology and financial statements. The class encouraged them to make better business decisions from evaluating financial data and manage the politics of budget setting and negotiation. Key performance indicators (KPIs) and management of staff sickness were also discussed.
- In June 2016, 32 Band 6 staff nurses, attended a professional development masterclass which explained their future role and the trust expectations of them. We did not speak with anyone who had attended.
- Sustainability of the service was under discussion with future plans for site amalgamation being considered.
- The trust were working to a programme in collaboration with the Virginia Mason. Staff we spoke with were aware of this however had not yet been involved with any projects or had specific feedback based upon this.

Maternity and gynaecology

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

Information about the service

The Women and Children's Centre at the Princess Royal Hospital (PRH) provides gynaecology services, as well as a consultant-led maternity unit (CLU), and a midwifery-led unit (MLU). PRH opened its gynaecology service on 29 September 2014 and the consultant-led maternity unit on 30 September 2014. Both services were previously at the Royal Shrewsbury Hospital.

Maternity services in Shropshire operate a 'hub and spoke' model of care with the hub being the main consultant-led unit at the Telford PRH site, and the spokes being the five MLUs in Shrewsbury, Telford, Ludlow, Oswestry and Bridgnorth. These MLU's are staffed and run by the local community midwifery teams. There are a further two community midwife bases in Market Drayton and Whitchurch.

In 2013/14, when it was located at the Royal Shrewsbury Hospital, the CLU had 3,978 deliveries. Wrekin MLU had 362 deliveries in the same year. The total number of births for 2015/16 was 4,860 with 82% of these at the consultant unit and 17% in an MLU or at home.

The Wrekin MLU is located on the PRH site but not within the Women and Children's Centre. The unit has four labour rooms and 13 postnatal beds.

The antenatal ward has 13 beds and one bereavement room, the postnatal ward has 23 beds and triage is a four bay assessment area. One bay within the postnatal ward is specifically for transitional care babies. The CLU has 13 delivery rooms, including one with a birthing pool. Gynaecology services consisted of an in-patients ward (ward 14) where up to 12 in-patients could be accommodated. There was also an Early Pregnancy Assessment Service (EPAS) and a Gynaecology Assessment Treatment Unit (GATU). The service also offered Colposcopy and Hysteroscopy service and Gynaecology Oncology. The service offered medical management (termination) of pregnancy for woman with complications of pregnancy up to 16 weeks gestation. The gynaecology department did not offer any other type of termination of pregnancy service.

The hospital provides a community midwifery service, who care for women and their babies both antenatally and postnatally and all teams provide care in labour within the MLUs. The main hospital operating theatres are used for gynaecological surgery.

The consultant-led unit has the capacity to deliver for 6,000 women. The unit has seen an increase in women choosing to have their baby there since the centre opened, with approximately 85% of all women booking their pregnancy at the trust giving birth to their baby at the CLU.

This inspection was a focused follow up from the 2014 inspection. We rated this service as good overall with safe requiring improvement and the other domains were rated as good. Areas for improvement included staffing levels, incident reporting, serious incident investigation process, and shared learning was inconsistent. The service did not have a vision beyond the restructure or additional staff recruitment. Data collection and monitoring could not be relied upon, and the dashboard was not location specific.

We visited the Wrekin MLU on our unannounced inspection on 1 November 2016 and again during our announced visit

Maternity and gynaecology

on 13 December 2016. We visited gynaecology services on the in-patient ward 14, EPAS and GATU. Within gynaecology services, we spoke with 13 staff, 10 patients and viewed eight patient records.

At PRH, we visited the consultant led delivery suite, the antenatal and postnatal wards, triage and antenatal clinic. We did not inspect the community service provided from Wrekin MLU, Whitchurch or Market Drayton or outpatients. However, we spoke with several community midwives and staff within outpatients. We talked to 74 members of staff; this included a combination of medical staff, as well as nursing and midwifery staff. We also spoke with nine women or partners and reviewed 10 sets of notes. We held a focus group for which four community midwives attended.

Summary of findings

We rated this service as required improvement because:

- Service-wide sharing of learning from serious incidents was not evident, not all staff could give examples or learning from incidents, implementation of actions was not always timely and there was limited learning across the maternity service, including the five MLU's.
- Communication of incident learning was not consistently service wide or fed down to all staff and was reliant on staff requesting or seeking feedback.
- The maternity service chose not to use the maternity specific safety thermometer and there was inconsistent display of quality and safety metrics across maternity departments.
- Medicines management was poor in several maternity wards despite pharmacy audits raising concerns. There was poor compliance with the checking of maternal and neonatal resuscitation equipment across maternity.
- Medical outliers on the gynaecological ward affected access and flow of patients requiring gynaecological care. There was no assessment of staffing requirements in relation to these patients.
- Appraisal rates were below trust target of 100% for all staff groups.
- We observed poor handovers between both midwifery and obstetric staff; they lacked leadership, organisation and consistency.
- Midwives on Wrekin MLU were concerned for safety due to staff moves to cover the delivery suite. There was a discrepancy between formal and informal monitoring of escalation processes for this MLU.
- Staff told us their awareness and knowledge around learning disabilities was not as good as they needed.
- The maternity service was in a transition period of change and although new senior leaders had begun to make positive changes, we had concerns as to whether this service had an embedded safety and learning culture.

Maternity and gynaecology

- Governance processes were under review at the time of our inspection. We saw evidence that although processes were in place, they were not fully embedded in the culture of the service.

However,

- New leaders in post since September 2016 demonstrated drive, motivation and passion to take the service towards a positive learning and safety culture.
- There was a positive incident reporting culture. Staff understood the importance of reporting and learning from incidents. Serious incident investigations had improved and involved families in the process.
- Staff were kind and professional and attentive to patients' needs. Patients felt informed and involved in their care.
- Policies and procedures were based on up-to-date, evidence-based guidance. Risk registers were up-to-date, showed clear ownership and actions completed or in progress. Senior managers recognised areas for improvement and engaged with staff to drive improvement.
- Overall, patient outcomes were better than the national average.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Service-wide sharing of learning from serious incidents was not evident, not all staff could give examples or learning from incidents, implementation of actions was not always timely and there was limited learning across the maternity service, including the five MLU's.
- The service did not utilise the maternity specific safety thermometer and did not display results for the public to see.
- Medicines management was poor on Wrekin MLU and delivery suite, despite pharmacy audit results raising issues previously. This included unsafe storage of intravenous fluids and a lack of temperature control of some medicines.
- Not all equipment was appropriately maintained and clean for use.
- Infection prevention and control audits for delivery suite were below the trust target in November 2016.
- Staff did not consistently check adult and neonatal resuscitation equipment in line with trust policy.
- Staff mandatory training rates were below the trust target of 100%.
- We observed an information governance breach on Wrekin MLU.
- Not all staff received direct feedback when they submitted an incident report.
- We observed an incident involving poor practice in relation to telephone advice on Wrekin MLU.
- The escalation process requires strengthening particularly in relation to monitoring staffing levels on Wrekin MLU.
- Triage staff were concerned about untimely access to obstetric review during busy periods.
- We observed an example of unsafe delivery suite co-ordination and ineffective 'safety pauses'.
- Some staff could not always easily find trust policies and procedures on the intranet when required.
- Medical staff did not routinely review high-risk postnatal women because they did not conduct daily ward rounds on this ward.

- Wrekin MLU midwives told us they did not have timely access to paediatrician support when they required it for babies born on the unit.

However:

- There was a positive incident reporting culture with staff aware and able to describe recent incidents within their department.
- Serious incidents were robustly investigated with lessons learnt and actions to improve implemented. We saw evidence of changes in practice.
- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children.
- The service kept medical records securely in line with the data protection policy. Midwives could obtain records easily when women arrived in labour out of hours.
- Consultant obstetric cover for delivery suite met national standards.

Incidents

Maternity

- The patient safety manager produced a monthly obstetric patient safety update to inform the governance group of all incidents across the trust including trends, themes and updating progress for serious incident investigations. For 2014/15, there were 782 incident reports, in 2015/16 there were 688 incidents reported and from April 2016 to the time of our inspection in December 2016, 466 incidents.
- Between 1 January 2015 and 31 December 2016, there were 917 clinical incidents reported including 535 no harm/near misses (58%), 357 minor harm (39%), 16 moderate harm (2%), nine severe harm (1%). No moderate harms or above had been reported since July 2016.
- The number of incidents reported for Wrekin MLU was 116 of those, 98 (84%) no harm/near misses, 18 (16%) minor harm, none reported as moderate or severe harm.
- There were no reported 'never events' during the period 1 November 2015 to 31 October 2016 for both maternity and gynaecology services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the NHS Serious Incident Framework 2015, from November 2015 to October 2016 the trust reported eight serious incidents (SIs) in maternity and gynaecology. All these incidents occurred at PRH. Four were classified as maternity/obstetric incidents meeting SI criteria, one grade three pressure ulcer, one surgical/invasive procedure incident and one diagnostic incident including delay.
- The trust reported stillbirths, neonatal and maternal deaths to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) as required.
- Staff reported incidents through the trust's electronic system and all staff were confident in using the system and knew what incidents required reporting. We saw there was a positive approach to reporting incidents.
- Staff told us that they could request incident feedback on the incident form but direct feedback was inconsistent. Only a few staff told us they had received feedback. Medical staff in particular felt they were only informed if they were required to provide a statement when things went wrong. The patient experience team published the anonymised serious incident and high-risk case reviews on the trust intranet for staff to read. Service wide learning was dependent upon staff seeking this information.
- Managers told us and we saw from minutes that incident feedback were discussed at monthly ward meetings based on the 'quality and safety report'.
- We saw an example of managers sharing lessons learnt from a serious incident with staff. A letter sent to all delivery suite midwives in December 2016, detailing actions taken following a neonatal death. The letter included several appropriate actions and learning. We also saw reminders of distinguishing fetal heart rate from maternal heart rate during monitoring in every labour room.
- The service had clear guidelines about which types of incidents required a detailed investigation, known as a root cause analysis (RCA). The Care Group patient safety report tracked the progress of all SI investigations for the Women and Children's care group. We saw actions from investigations were monitored and evidence that action

plans were completed and closed was recorded. Families were involved in all investigations and were invited to attend a meeting once the investigation was in the final stages.

- During the inspection, we viewed three recent root cause analysis reports. They showed there had been a full investigation, with evidence of the lessons learnt and practice being changed. The 'patient experience' lead midwife co-ordinates the process and oversees completion of action plans.
- An example of this process was evident in the investigation of a grade 3 pressure sore incident. During our inspection, we saw evidence that staff had put actions from lessons learnt from this incident into practice. This included staff awareness of the need to improve skin inspection during labour and a 'Safety Bulletin' that included information from the 'React to Red' pressure ulcer prevention national campaign. The service was developing a more robust maternity risk assessment to support staff in preventing skin damage that can occur from reduced mobility when having an epidural.
- Following the inspection, we reviewed a further five investigation reports, relating to the deaths of babies at the trust which had occurred since our inspection in 2014. We saw there had been an improvement in the quality of the investigations carried out since our last inspection. In all cases the investigation was carried out in line with trust policy and a rapid review meeting was held within 24-hours to identify any immediate concerns where appropriate. We also saw that in four of the five cases the parents had been involved. A full analysis of the issues had been completed in each case.
- We saw that in two cases key issues identified included communication between clinicians. On our inspection, some of the handovers we observed lacked detail and consistency. Three of the incident reports included issues regarding fetal heart monitoring. We saw that the trust had recently introduced a range of measures regarding fetal heart monitoring including commencing the installation of centralised monitoring, enhanced training for staff, weekly multidisciplinary meetings to discuss cases and simulation training. Although all of these measures are a positive step forward, they come 12 months after the last baby death was reported in December 2015.
- Newborn transport stabilisation 'pods' were purchased by the trust following learning from a serious incident and all MLU's had one in case a baby required transfer to hospital.
- We viewed the perinatal morbidity and mortality meeting minutes for September 2016, which showed an improvement in the detail provided when compared to our last inspection in 2014. There was evidence of persons present, discussions for each case and an action plan attached to each meeting. Two out of the four cases discussed identified what went well and learning points for improvement; the other two did not. We found that not all actions had target dates identified.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and to provide reasonable support to that person.
- Midwifery, nursing and medical staff were aware of their responsibility in relation to being open and honest when things go wrong. Senior nurses and midwives told us they had completed basic duty of candour training. Records showed 18 medical staff and 34 nursing and midwifery staff had completed training.
- From November 2015 to October 2016, 14 maternity incidents triggered the duty of candour process.

Gynaecology

- Data relating to gynaecology incidents have been reported under the surgery core service.
- Gynaecology staff gave us examples of when they reported incidents. There were two examples from a member of staff, one related to concerns she had with a locum doctor and where an urgent medical response was required for a patient with suspected ectopic pregnancy. In both cases, incidents were reported, responded to and lessons learned.
- The trust reported two gynaecology related SIs from November 2015 to November 2016.

Maternity safety thermometer

- The Royal College of Obstetricians and Gynaecologists (RCOG) launched the maternity safety thermometer in October 2014. The maternity safety thermometer

measures harm from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological wellbeing.
- The trust did not utilise the maternity-specific survey. The head of midwifery told us they were aware of the maternity specific thermometer but that they felt that the service collected the same information elsewhere. We reviewed data that the trust collected and found that the trust collected some data via the maternity dashboard however, they did not collect and review harm in relation to postpartum haemorrhage, separation of mother and baby and psychological wellbeing.
- The service submitted data to the national NHS Safety Thermometer patient care survey instead. This measures harm from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism. Results for these metrics are below for each of the wards.
- For the antenatal ward, results showed that there was 78-93% harm free care during February 2015 to August 2015 but improved to 100% May to December 2016.
- Delivery suite provided 85% harm free care in July 2016, 89% in August 2016 and 100% September to December 2016.
- The postnatal ward had a 45% harm free rate in January 2016, but from February 2016 had improved to 95% and 100% March to December 2016.
- Data provided by the trust showed that 100% of women admitted to all inpatient maternity wards and departments were assessed for the risk of venous thromboembolism (VTE) for the year to date 2016/17.
- The maternity wards did not display the NHS Safety Thermometer results for all patients and visitors to view at the entry to the clinical area. Managers told us this was because of a lack of display boards. Safety thermometer data was not included in the monthly care group safety and quality report.

Safety thermometer

- Gynaecology used the safety thermometer to measure quality and safety on the unit. The manager displayed the results at the entrance of the ward area and inside their office. The results were positive and suggested that the ward was providing harm free care for patients, staff and visitors. There were improvements noted, one example was for VTEs with compliance rates over 93% and we saw evidence of actions to seek improvement. 'Preventing surgical site infections' was 100%.
- Staff knew about the safety thermometer, had been involved in audits and told us they were 'very proud' of their ward.
- The manager confirmed they monitored the results of the safety thermometer closely and kept staff informed of results in informal meetings and through the communication book.

Cleanliness, infection control and hygiene

Maternity

- We saw every ward and department that we visited was visibly clean. All staff were compliant with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately and wore their uniforms in line with the trust policy, with arms 'bare below the elbows' practice.
- Overall, there were adequate hand cleaning facilities and hand gel dispensers. However, there was no hand gel dispenser near the delivery suite entrance and we saw patients and relatives searching for one as they came through the door.
- Staff encouraged the inspection team and visitors to 'gel their hands' in clinical areas, particularly on the delivery suite and Wrekin MLU.
- Hand hygiene results for October 2016 showed 100% compliance for the antenatal ward, postnatal ward and Wrekin MLU and 95% compliance for the delivery suite. Managers carried out audits monthly.
- On the delivery suite, we found corridors periodically cluttered throughout the day. For example; there were more wheelchairs than necessary in one corridor, and the passageway was obstructed.
- There had been no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia within maternity and gynaecology from 1 November 2015 to 31 October 2016.
- The trust monitored the number of surgical site infections (SSIs) from caesarean wounds. Data provided showed there were 44 SSIs during 2015/16, an average of 4.9% overall for the year. From April 2016 to

November 2016, 38 caesarean SSIs were reported, an average infection rate of 5.4%. This showed an increase in the number of caesarean SSIs for the current year. Nationally comparative data was not available.
- There were daily cleaning checks in place for which support workers and nursing and midwifery staff had designated responsibilities.
- The delivery suite infection prevention and control (IPC) 'quality and safety ward walk' records for November 2016 showed an overall compliance rate of 87%. This was below the trust target of 100% and actions for follow up and responsible persons identified.
- In the same IPC audit, Wrekin MLU scored 85% with actions identified for improvement. The trust policy was that if scores fell below 80%, the IPC team would follow up actions within 14 days.
- During our unannounced visit, we found the adult resuscitation trolley on Wrekin MLU was visibly dusty. At our announced visit, the trolley was visibly clean.

Gynaecology

- Gynaecology was 100% compliant for hand hygiene for October 2016 and managers audited this monthly.
- The department manager told us gynaecology had not had a MRSA infection for three years.
- A gynaecology department domestic assistant told us how proud they were of the high standard of cleanliness on the ward and showed us the award they had received from the trust for their good work. They showed us the cleaning schedule in place. This included daily cleaning in all areas including toilets, emptying and cleaning general and clinical waste bins and mopping floors.
- The ward manager for gynaecology showed us records of infection control monitoring. They undertook observational sessions to observe staff practice. This helped to monitor staff's handwashing techniques and prevention of surgical site infections by monitoring patient wounds, catheter care and peripheral line insertion. Managers conducted audits regularly in these and other areas in relation to infection control.
- There were food hygiene safety policies in place. We saw staff adhering to these in respect of food handling in ward and kitchen areas.
- The hospital used a green sticker system to identify that equipment was clean and ready for use. Overall, staff labelled clean equipment.

Environment and equipment

Maternity

- Emergency equipment trolleys and boxes contained the appropriate equipment required to manage specific maternity or neonatal emergencies.
- The adult resuscitation equipment was shared between the antenatal and postnatal wards, and was stored on the antenatal ward. This meant in an emergency the trolley would be transferred through several doors to reach the postnatal ward. Managers thought this had been risk assessed when the service moved to the new centre however; the resuscitation lead confirmed it had not. This meant there was no assurance it was available and accessible to all areas at all times.
- The postnatal ward had 'grab' boxes to use in emergencies such as a postpartum haemorrhage.
- Adequate equipment was available for use, including vital observation monitors, blood gas analysers and baby thermometers.
- There were sufficient cardiotocography (CTG) machines (used to monitor the baby's heartbeat antenatally and during labour) with a CTG in every labour room. We saw three machines on delivery suite with up-to-date servicing.
- The adult resuscitation trolley on the Wrekin MLU was stored in the community midwives' office, which was locked with a keypad. We raised this as an access concern in the event of an emergency on our unannounced visit. On our announced inspection visit in December, the trolley was relocated and accessible to all staff in the corridor close to the staff office.
- We saw records showing that delivery suite staff carried out daily checks of equipment such as the neonatal resuscitation equipment and adult emergency trolleys. The ward manager told us these were missed if the ward was acutely busy. From January to October 2016, records showed the delivery suite had an average compliance rate of 92%, Wrekin MLU 93%, the antenatal ward 93% and the postnatal ward 89%. The target compliance was set at 100%.
- We observed and records confirmed that compliance with checking adult resuscitation equipment was poor for both Wrekin MLU and the antenatal ward. For November, compliance was 87% for Wrekin MLU and 74% for the antenatal ward against the target of 100%. We saw the process was that if below 90% compliance, the manager was required to investigate the reason and

if below 90% for two months, an incident form was generated. We spoke with the resuscitation lead who said this was an on-going issue and they were working with the ward managers to rectify the poor compliance.

- We reviewed neonatal resuscitation equipment on the delivery suite, and found checks were performed but not consistently. Although checks should be performed daily, we noted that some of the resuscitaires had two days of December (for 14 days of the month) where checks had not been undertaken. The midwife in charge of checklist records confirmed checks were missed for resuscitation, medicines and other checks were not always signed for and the manager confirmed when the ward was acutely busy, these were missed.
- On the Wrekin MLU, we found not all equipment had annual maintenance checks. Four pieces of equipment were overdue maintenance checks. We saw maintenance records that confirmed that not all equipment was adequately maintained. We also found the seal on the heated mattress was broken in the new born transport stabilisation 'pod'. We raised this with the midwife who took action to replace it immediately.
- The trust had addressed previous concerns raised at our 2014 inspection regarding emergency exits through ward doors. Access through entrances was with staff swipe cards and exit arrangements had been changed to a press release button for ease in cases of emergency.
- The antenatal triage was located inside the entrance of the antenatal ward, which was located on the ground floor of the Women and Children's centre. The delivery suite and theatre was located on the first floor.
- The Wrekin MLU was located a distance from the consultant-led delivery suite. This meant that when women required an emergency transfer to the delivery suite, it was through a public hospital corridor. Senior managers told us it took approximately seven minutes to transfer a woman to the delivery suite in an emergency but this was not formally monitored.
- Two obstetric theatres were co-located on the delivery suite. Elective lists were staffed by a dedicated team to ensure that emergency theatre activity could run alongside, avoiding unnecessary delays to the elective activity.
- The neonatal unit was located next to the delivery suite department. Staff we spoke with informed us neonatal staff could attend emergencies quickly when required.
- Staff, including a member of the estates team, told us faulty equipment was repaired promptly based upon priority. Staff confirmed there was sufficient equipment to carry out their role.
- The delivery suite had a refrigerator to store specimens prior to transport to another hospital for testing. There was a daily checklist for checking the refrigerator temperature; however, there was no record of minimum or maximum temperatures. The manager confirmed this should be checked and recorded and told us they would find out what the safe range was. At the time of our checking, the refrigerator was showing that the temperature was 'defrosting'. We alerted the manager and we heard them asking the ward clerk to report to estates immediately.

Gynaecology

- The adult resuscitation trolley was located in the central area of the ward, which was accessible to staff in an emergency. We saw records that showed staff checked this daily.

Medicines

Maternity

- Medicines management was a concern at both our unannounced visit to the Wrekin MLU and at our announced visit at the delivery suite.
- The Wrekin MLU utility room door, where medicines were stored, was unlocked. This door had a digital lock and should have been kept secure. A midwife on duty confirmed it was usually open for ease of access.
- Intravenous fluids should be stored in a locked cupboard for security purposes. At Wrekin MLU, the cupboard storing these fluids was unlocked and the keys were in the lock. We checked the door lock later the same day, after raising the safety concern, and found it was still unlocked.
- In the same utility room, we found five out of date intravenous fluid bags left in the sink with one with a giving set inserted. The midwife on duty told this was used for Women's Services Assistants (WSAs) to practice running fluid through the giving set. We raised this as a concern for many reasons including the unlocked door and the suitability of WSA's practising with intravenous fluids. On our announced visit, the fluid bags had been disposed of appropriately.

- Another issue found within the Wrekin MLU utility room was nine ampoules of oxytocin, a medicine used to help induce labour and aid the delivery of the afterbirth, left out of the refrigerator on delivery trolleys. We discussed this with a pharmacist who said if staff maintained the room temperature at less than 25 degrees and kept records to confirm this, and used the medicine within a month this would be suitable. However, the room temperature was not monitored and we found the room felt very warm. The midwife on duty told us that there was a possibility that a few ampoules of the medicine could be left out for weeks or months. Our concern was that the medicine would be ineffective if stored incorrectly.
- These issues and safety concerns were raised at the time of our unannounced visit and the head of midwifery took immediate action. At our announced inspection, the trust had rectified identified issues. The oxytocin was stored in the refrigerator and a sign was displayed notifying staff that it must be stored in the refrigerator at all times. The utility room was locked and all medicines inside were stored appropriately.
- During the announced inspection, we found that medicines including intravenous fluids stored in the delivery suite utility room were not locked appropriately. There was a notice on cupboards reminding staff of correct medicines storage. The delivery suite medicines storage and handling audit for December 2016 identified medicines storage as an issue, with improvement actions allocated to the ward manager.
- On Wrekin MLU, there was not any appropriate signage on the door to the room where Entonox gas cylinders were stored which is against HTM02 guidelines.
- Registered midwives may supply and administer, on their own initiative, any of the substances that are specified in medicines legislation under midwives exemptions. We viewed six prescription records and found that midwives did not consistently prescribe medicines given in labour such as Entonox (gas and air) when compared to the woman's labour record. This is against medicines legislation, and Nursing and Midwifery Council practice standards. We raised this with the deputy head of midwifery who confirmed the trust did not formally audit this.

Gynaecology

- We saw that medicines and intravenous fluids were stored securely on ward 14. The clean utility room had keypad locks on the doors and medicines inside were appropriately stored in locked cupboards or refrigerators.
- We saw logs that demonstrated that controlled drugs were administered appropriately and we observed controlled drugs were checked during the handover process, two nurses ensured the count was correct. Records showed this occurred twice a day.
- Refrigerator temperatures were recorded daily and we saw they were within acceptable limits.
- We observed a nurse administering medication to patients on the ward. This was completed ensuring patients received the right medication at the right time and in the way they preferred to take it. The nurse administering medication signed the medication administration record (MAR) that these had been administered to the patient at that time and date.
- We saw instructions on MARs were legible and medicines were prescribed with the prescribing doctor's signature.
- When changes to prescriptions were required, doctors arranged this and pharmacists attended the ward to review medicine changes. There were pharmacist 'runners' who helped to ensure patients were not kept waiting for medication including to take out (TTO) medications.

Records

Maternity

- Staff and women informed us that all women were given pregnancy record folders that they retained and took to appointments throughout their pregnancy. Following the birth, these were returned to the woman's medical records.
- The trust used both electronic and paper methods to record patient care and we saw these were stored securely in all areas we visited. Electronic records (on the trust's computers) were only accessible by staff that had specific access rights.
- During our unannounced inspection on the Wrekin MLU, we observed a midwife give their computer access details to a support worker who usually worked at another site. Records showed for September 2016 that information governance training was below the trust

target for maternity and gynaecology staff at 86% and 88% respectively. Senior management meeting records showed ward managers were requested to send staff monthly reminders to book training.

- Current episode of care records and assessment charts were kept at the patient bedside so that these were accessible to staff delivering care and for other relevant health care professionals. This applied to both maternity and gynaecology patients.
- Parts of the maternity care pathway were recorded electronically and others on paper. For example, the booking appointment (the first appointment with a midwife to book the pregnancy for care at the trust) was recorded electronically, the pregnancy record was on paper, labour was both electronic and paper, postnatal inpatient care was electronic and community postnatal care was on paper. Midwives expressed frustration with this process and found it time consuming.
- An audit of 45 patient records across maternity at PRH took place in July 2016 and was reported in November 2016. This showed significant improvements in the way records were managed since the previous audit in 2014. However, there were still areas of concern and recommendations for improvement, for example, medical staff must sign and include their GMC number stamp on records following patient treatment. Medical staff had signed and stamped their GMC number in the records we observed.
- We saw venous thromboembolism (VTE) risk assessments were a mandatory field on the electronic patient record system. Maternity audit results for VTE assessment were consistently 100% for year to date 2016/17.
- Staff routinely used the Personal Child Health Record ('red book') for each baby to record birth details. Parents retain this record for use during the early years until their child is five years old. This record aids communication with health visitors for the Healthy Child Programme.

Gynaecology

- Gynaecology care records contained risk assessments and relevant care plans. Care plans were generic and the manager agreed care plans required an improved person-centred approach to reflect patient individual needs.
- Staff stored medical records in filing trolleys that were protected by a security code. This meant only authorised staff had access to the records.
- We reviewed eight gynaecology patient records and found they held relevant clinical information, which was legible, signed and dated in accordance with guidelines.
- The service offered medical management of women with complications of early pregnancy (up to 16 weeks gestation). We saw that relevant paperwork and completed consent forms. The service did not offer terminations of pregnancy.
- On the inpatient gynaecology ward, we accompanied doctors on a ward round and saw that patients' notes were stored securely in a cabinet throughout and taken to each patient. We saw doctors writing up notes afterwards with clear instructions for staff and other health care professionals to follow. Later, we saw that nurses had made the necessary changes and updates to patients' care plans.
- VTE risk assessment audit results year to date were 93% and was 'red flagged' for improvement. We saw in meeting minute records that actions to improve were discussed.

Safeguarding

- The trust's safeguarding mandatory training target was set at 80%. At the time of our inspection, the trust reported maternity services compliance rates for safeguarding adults level 2 98%, 100% safeguarding children level 2 and 86% for safeguarding children level 3.
- Medical staff (obstetricians and gynaecologists) training compliance was above target at 83% for adult safeguarding but below target at 61% for safeguarding children level 2 training. They did not hold level 3 safeguarding children training.
- For safeguarding level 3 training, delivery suite staff were just below the trust target with 79% of staff up to date. The other maternity wards and departments were above the 80% target with a range of 83% (antenatal ward) to 92% (postnatal ward). No medical staff or gynaecology staff received safeguarding children level 3 training.
- The trust told us and we saw evidence that mandatory safeguarding training included child sexual exploitation, female genital mutilation and domestic abuse awareness and encouraged staff to access further training through the Local Safeguarding Children Board.

- The midwifery safeguarding lead told us there were plans to increase the required number of hours for safeguarding children training to match the recently updated national recommendations.
- Midwives were able to make referrals to the supporting women with additional needs (SWAN) pathway. The SWAN group met monthly; meetings were chaired by the safeguarding lead midwife and attended by multi-disciplinary professionals including health visitors, family nurses, teenage pregnancy specialist midwives and community midwives. We saw meeting minutes, which showed discussion of new referrals and high-risk cases. The trust had recently provided safeguarding supervision training to 10 midwives with a plan to increase the number in the future. Staff told us this was a positive step to provide support to midwives in this area, which can be emotionally challenging.
- There were safeguarding link midwives in all ward areas to support the safeguarding team and to increase midwife skills and competence in this area.
- The staff we spoke with told us they followed safeguarding guidelines and told us they accessed them via the intranet. Staff were able to tell us who the safeguarding leads were for the trust.
- Staff could explain the process they followed if they had any child or adult safeguarding concerns. This including speaking with the hospital's own safeguarding lead, speaking with their line manager, and, if necessary out-of-hours they would telephone social services directly. Midwives said they felt confident in making referrals directly, which included making a telephone call followed by a referral form.
- There was a business case in progress for sourcing additional resource within the safeguarding team. The lead safeguarding midwife covered all children's safeguarding, domestic abuse and female genital mutilation referrals.
- There was a newborn standard operating procedure in place and in date (due for review in May 2018). This stated that the newborn infant should be cared for in a secure environment to which access is restricted and a reliable baby security system enforced.
- The trust had an electronic tagging system on the postnatal ward to alert staff if a baby was taken off the ward. The alert made a loud sound in all maternity clinical areas to alert staff. We tested this system during our inspection with a baby (with parental consent) and staff immediately responded to the alarm. This system was not used in the Wrekin MLU.
- Clinical areas displayed posters about forced marriage and domestic abuse, providing contact details for support agencies for women to see. Staff received training on safeguarding issues such as female genital mutilation and domestic abuse as part of their mandatory safeguarding training.

Mandatory training

Maternity

- All staff were required to attend mandatory training. This training was needs assessed to ensure professional updates and clinical skills were relevant to the staff member, according to their role and area of work.
- We saw the maternity-specific mandatory training guideline, which included the training needs analysis for 2016-2019. This detailed what was required for midwives, women's support assistants and medical staff and how often. There were 35 modules in total and included appropriate modules such as obstetric emergency multi-disciplinary skills drills, a fetal monitoring package, newborn life support skills, early recognition of the severely ill woman, post-operative recovery skills and neonatal stabilisation. Compliance rates for all modules were provided at service level only and not broken down by unit. The target was set at 80%.
- Care of the severely ill women recorded as 95.8%. Newborn life support training was reported at 93%. The maternity service compliance rate for the neonatal stabilisation-training course was 82%. For fetal electronic monitoring training, 80% of maternity staff were up to date at the time of our inspection.
- Compliance with basic life support training was 74%. Advance life support for adults was not mandatory for midwifery staff.
- Care group governance meeting minutes for November 2016 showed that 84% of midwives, 74% of Women's Services Assistants (WSAs) and 86% of obstetric medical staff were up-to-date with obstetric emergency skills. The target was set at 80%.
- There were up to 16 statutory mandatory training modules depending on role and area of work. These

included: fire safety; patient manual handling; hand hygiene competence; basic life support; safeguarding adults and children; information governance; slips, trips and falls; equality and diversity; and conflict resolution.

- We received data from the trust for staff statutory mandatory training compliance rates for November 2016. Mandatory training compliance for delivery suite staff overall was 66% with 14 out of 15 required modules below the trust target. The lowest being food safety (49%) and seven modules below 60%.
- Postnatal ward staff mandatory training compliance for the 15 modules was overall 84% with 14 modules below the 100% target.
- Antenatal ward staff mandatory training compliance for the 15 modules overall was 71% with 13 modules below the 100% target.
- For the Wrekin MLU, overall mandatory training compliance was 88% with 14 of the 15 modules below the target however, 12 were above 91%. For advanced newborn life support training, 87% of midwives on the unit were up-to-date.
- We raised a concern that basic life support training compliance rates for the consultant-led unit were significantly below the trust target of 100% with delivery suite at 52%, and the antenatal ward at 57%. The postnatal ward and the outpatient clinic were better with 79% and 75% respectively. We told senior managers of this concern and they told us they would address this immediately.
- Records for November 2016 showed that 10 out of 14 required mandatory training modules, gynaecology staff compliance was meeting the 100% target. The three modules below target were food safety (0%), conflict resolution (17%), and equality and diversity training (0%).
- Midwife-led unit and community midwives were required to attend The Resuscitation Council UK Newborn Life Support training and records for November 2016 showed 97% were up-to-date.
- For CLU staff, the same records showed that 79% of midwives and 77% WSAs were up-to-date. This was below the target of 80%. The records showed that staff out-of-date were prioritised to receive the training.
- Senior managers told us they monitored staff training compliance through the care group governance meeting and ward managers were told to prioritise those out-of-date. We saw meeting records that confirmed this with plans to prioritise and book training dates.
- The trust had secured funding for advanced cardiotocography (CTG) training for all labour ward co-ordinators and sessions were planned for July 2017. This was to improve clinical decision-making and midwife support for electronic fetal monitoring interpretation. In addition to this, all midwives and doctors were in the process of completing a 'Sign up to Safety' CTG training package. The trust have also purchased an interactive computer-based training package in fetal monitoring and maternity crisis management to improve core knowledge and skills. All current doctors (bar one) have completed it and will be expected to complete it as part of their induction. All delivery suite midwives will be completing it also.

Gynaecology

- Sixty-one percent of gynaecology staff had received training in adult life support, which was below the trust target. The ward manager was a critical care nurse and as such had completed advanced life support training.

Assessing and responding to patient risk

Maternity

- The maternity service had a clear policy on antenatal clinical risk assessment, setting out a colour coded criteria for women who were suitable for low (green) risk care (delivered by community midwives and MLU births), those who were medium risk and required closer monitoring (amber) and those classed as high risk (red) and needed care under a consultant. Midwives were able to described this policy and confirmed that risks were discussed with women at each stage of the process.
- Risk assessments could change with each antenatal appointment. Finally, when a woman reached 36 weeks of pregnancy, a final decision on the place of delivery was made. Decisions were made involving the woman and the midwives.
- Community midwives referred women with identified risks at the booking visit for obstetric review and onward pregnancy planning. Problems identified throughout pregnancy were referred for obstetric review on the day assessment unit or triage if more urgent.

Maternity and gynaecology

- A local survey of all women who gave birth at the trust during September 2016, asked what women were informed about when choosing where to have their baby. The survey showed that 91.7% of women were informed that MLUs were staffed solely by midwives, 97.3% were aware that if a problem arose during labour they may be transferred to the consultant unit and 82.9%, were aware of how long it would probably take to transfer from the MLU to the consultant unit.
- The antenatal triage operated as an emergency department model with women prioritised based upon risk with the aim of assessing risk within 15 minutes of arrival. Triage midwives told us that accessing medical review was not always timely. We were told that the doctor covering the labour ward also covered triage and this affected how long women waited to be seen in triage. This was not formally monitored by the service.
- The antenatal outpatient department had a clear process in place for women who 'did not attend' (DNA) their appointments. Staff explained they completed a pro forma for every DNA and if a woman DNA three consecutive appointments, a safeguarding check was undertaken.
- The antenatal ward held a 'safety pause' twice daily to discuss any concerns that required action or escalation. During observations of these, ward midwives did not contribute to the discussion to ensure effectiveness and there was a lack of leadership.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements, smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use and referred for scans as required to help identify babies who were not growing as well as expected.
- National early warning scores were developed to assist health professionals to detect the early deterioration of patients becoming critically ill with this adapted for maternity and neonatal use. The Modified Early Obstetric Warning Score (MEOWS) and Newborn Early Warning Score (NEWS) system were in place for women and babies.
- We reviewed seven records of postnatal women and found that five had incomplete Modified Early Obstetric Warning Score (MOEWS) records.
- We spoke to a student midwife who was able to explain the process followed in an emergency including the '2222' call out and the location of the resuscitation trolley. They told us they had received advanced life support training.
- There was a policy and procedure in place for escalation and safe transfer of patients from the MLUs to the consultant led unit where there were concerns.
- A service-wide review of transfers by ambulance to the CLU between April and September 2015 concluded that women were not being unnecessarily transferred and outcomes for those who were transferred were good.
- The maternity service had introduced the neonatal early warning scoring (NnEWS) system following learning from a serious incident. Practice changed to ensure every baby following birth received a full set of vital observations. If any abnormal findings identified, observations would continue for as long as required. We saw two NnEWS charts that were incomplete and not as per trust policy.
- Some babies required regular observations such as those born to diabetic mothers or if they passed meconium (the earliest newborn stool) during labour.
- Medical staff told us they were confident with the maternity sepsis pathway and microbiology support and collaboration was effective. We saw the trust's perinatal sepsis guideline 'Sepsis related to the antenatal, intrapartum and postnatal period' due for review in September 2016. This included the nationally recognised 'Sepsis 6' care bundle and the maternity sepsis screening tool, in line with Sepsis Trust UK guidance. We asked the trust for sepsis management audit results but they told us results were due to be presented in June 2017.
- We observed medical reviews of women and saw these took place around the patient board on the unit rather than at the bedside, which meant women were not involved in the process. Handovers between medical staff and midwives lacked detail and consistency.
- We observed the delivery suite night to day shift handover on each day of our announced inspection. This handover involved the co-ordinator, midwives and medical staff. We found the first day handover given by the co-ordinator to be disorganised and lacked oversight of all women on the ward and therefore

unsafe. An example of this was a woman transferred to delivery suite that the co-ordinator had no knowledge and this caused confusion for other staff throughout the shift.

- On the second day on the inspection, we re-visited delivery suite to observe another handover and a different co-ordinator was in charge. We observed a methodical and robust handover of essential clinical information and effective leadership.
- Maternity theatres used the World Health Organisation 'Five Steps to Safer Surgery' checklist. The team brief process was rigorous to ensure patients' safety and we saw that each individual respected each team member's priorities. Audit results showed 100% compliance from July to October 2016.
- Although we observed effective teamwork within the theatre team, we observed that the theatre team and delivery suite team did not communicate regarding the women on the theatre list and this meant the delivery suite co-ordinator and medical team lacked oversight of all women within the department.
- There was a process in place to document telephone advice given by midwives to women. This included filling out a record sheet of the advice given, which was filed in the woman's medical records. On our unannounced visit to the Wrekin MLU, we observed an example of where this process was not followed. A ward clerk took a call from a pregnant woman asking for advice about her headache. Instead of the midwife taking the call, the ward clerk asked the midwife and gave the advice to the woman, which was to take paracetamol. We were concerned that the woman did not have a thorough assessment by a midwife about the potential cause for her headache when headaches can be a sign of a serious maternity-related condition such as pre-eclampsia. We confirmed that neither the ward clerk nor the midwife completed a telephone record sheet for the conversation.
- The trust confirmed post inspection that they did not audit compliance with their telephone contact standard operating procedure.
- Postnatal ward midwives told us that consultants did not routinely review high-risk postnatal women or conduct ward rounds. Staff accessed the junior medical staff as required but staff told us senior review was not routine practice.
- The trust had a policy in place for the transfer of postnatal women from the consultant led unit to the MLUs. The policy states that after an initial assessment following birth, women can be transferred if the criterion was met. The criteria excludes women who were less than 24-hours post caesarean section and/or were not mobile and babies who had not fed in the first 12 hours, neonatal jaundice requiring medical treatment, babies with an abnormality, nasogastric tube feeds or with a temperature of less than 36°C. There were 1471 women transferred for postnatal care to the Wrekin MLU between 1 November 2015 and 31 October 2016.
- The trust told us it does not currently audit the transfer of women from the consultant unit to the MLU as this is part of the planned process, however, they are planning an audit of handover of care between the CLU and the MLU during 2017/2018 as part of their audit programme.

Gynaecology

- The Royal College of Physicians developed the national early warning score (NEWS) to standardise the assessment of illness severity and determine the need for timely clinical escalation during an acute illness or deterioration. Gynaecology areas used the NEWS system and we saw records to show these were appropriately completed.
- Ward 14 was supporting medical outliers alongside gynaecology patients because of the lack of available medical beds. This increased acuity on the ward and there was no process to match nursing skills to patient needs. For example, there was not always a sepsis-trained nurse on shift and staff told us it could be difficult to manager patients with dementia care needs. This increased patient acuity There was no formal monitoring process to identify the impact this had upon the ward overall or the frequency in which this was happening. Senior managers told us addressing this was a key priority and during the short-term, the medical team reviewed medical patients daily and moved them to medical wards whenever possible

Midwifery staffing

- The trust employed 141.9 whole time equivalent (WTE) midwives, 34.6 WTE Women's Services Assistants (WSAs), 4.9 WTE registered nurses and 12.64 clerical staff within maternity and gynaecology at PRH. There were some vacancies across maternity departments with 8.0 WTE band 6 posts, 4.4 WTE band 5 posts, 5.0 WTE maternity support worker posts and 0.69 clerical posts available.

- There were 10.7 WTE band 7 midwife sonographers and 1.2 WTE support assistants within PRH maternity outpatients.
- Antenatal triage was staffed daily with two midwives and a WSA and was staffed with a separate rota to delivery suite. Rotation between areas was in operation for staff to maintain skills.
- Delivery suite planned staffing was seven midwives plus two midwives dedicated for theatre and recovery (on the three elective list days only) and three WSAs per 12 hour shift. One of the midwives included the shift co-ordinator who was responsible for midwife allocation and oversight of delivery suite safety. This was the planned staffing levels 24 hours a day, seven days a week.
- Data provided by the trust showed that for October and November 2016 (61 days), delivery suite met the planned staffing levels 58 days (95%) for day shifts and 56 days (92%) for night shifts. For Wrekin MLU, staffing levels met the planned level 55 out of the 61 days (90%) for both day and night shifts.
- The trust determined the number of midwives required for delivery suite per shift from the review of staffing that took place in 2014 following our previous inspection. The number increased from six to seven. Staff told us that the trust was planning to increase this number to eight following the Birth-rate Plus review.
- The trust had recently commissioned a 'Birth-rate Plus' workforce planning review and the results were expected in early 2017. The National Institute for Health and Care Excellence (NICE) endorsed this tool. Birth-rate Plus will determine the trust's maternity staffing requirements to ensure safe care.
- Staff told us seven midwives for delivery suite was insufficient and was why midwives from other areas, most commonly Wrekin MLU, were 'pulled' to cover either for sickness or because of high acuity.
- For the Wrekin MLU, planned staffing levels were two midwives per 12-hour shift. On both our unannounced and announced inspections, actual staffing was one midwife. Several midwives told us that they were concerned that staffing levels persistently fell to one midwife on Wrekin and this made them feel vulnerable. The midwives on Wrekin MLU informally monitored the number of times staffing fell below planned levels.
- We reviewed this informal log and during a 4-week period (November to December 2016), there were 12 incidences when there was one midwife on the unit including two occasions when both midwives were moved areas. We found that the monitoring and recording of staffing escalation on Wrekin MLU was inconsistent between the formal and informal processes in place.
- Daily staffing levels for each department was visible on display boards at entrances for patients and visitors to see.
- On the day of our inspection, the elective theatre list was suspended due to staffing and acuity levels on the delivery suite.
- For elective maternity theatre lists, there were two designated midwives for these so that there were seven midwives for the rest of delivery suite. This resource was unavailable out-of-hours and this was an identified risk on the risk register.
- The midwife to birth ratio was monitored monthly on the maternity dashboard and within the care group executive team meetings.
- The Royal College of Midwives recommends a ratio of one WTE midwife to 28 (1:28) hospital births and 1:35 for birth centres and homebirth births. The maternity dashboard provided this data for each month and was consistently 1:30.
- The maternity service had 11 supervisors of midwives (SOMs), four of whom carried double caseloads due to recent resignations. A full time SOM was in post to mitigate the risk in the short-term.
- The sickness rate for maternity staff was stable during April to September 2016, at 3%.
- The postnatal ward manager increased the number of WSAs from two to three and this meant there was one WSA to each midwife the day shift. Both midwives and WSAs told us this improved the effectiveness of running of the ward and gave WSAs ownership for designated women alongside a midwife. They told us this improved their job satisfaction and team working on the ward.
- The trust did not have a consultant midwife in post and the head of midwifery confirmed this was not a plan in the short-term future. The Royal College of Obstetricians and Gynaecologists guidance 'Safer Childbirth' recommends that all midwifery units should have at least one WTE consultant midwife (based upon births per annum).

Nursing staffing

- Planned staffing levels for the gynaecological ward (ward 14) were monitored and displayed, for example

during October 2016 101% of registered nurse day hours were filled as planned, 100% of unregistered care staff day hours were filled as planned, 100% of registered night nurse hours were filled as planned and 100% of unregistered care staff night were filled as planned.
- The service determined gynaecology nurse staffing numbers by the number and needs of patients. The ward manager reviewed staffing arrangements weekly. On the day we visited the gynaecology inpatient ward it was at full capacity with all 12 patient beds occupied. Of these, four patients had medical needs, one had surgical needs and seven had gynaecological needs.
- As planned on the off duty rota there was a nursing sister on duty, a registered nurse (band 6) and a health care assistant (HCA). This meant that each registered nurse was responsible for seven patients. However, this did not take into account meeting the specific needs of the medical outlier patients and staff told us that this could be a problem. The medical outliers increased the acuity of the patients and there was no tool in place for measuring this acuity.
- On the gynaecology assessment treatment unit (GATU), there was one band 6 nurse and an HCA on duty. When there was a theatre list, there was an extra nurse on duty to assist with this. The early pregnancy assessment service (EPAS) was nurse-led with two band 6 nurses on duty at all times. At the time of the inspection, these units were staffed as planned and the sister and unit manager monitored staffing daily.
- The sickness rate for gynaecology staff was 5% for September 2016. This had steadily increased from 2% in April 2016.
- There were no staffing vacancies for the gynaecology department.
- We asked the trust to supply us with data on bank and agency usage for November 2015 to October 2016. The data showed that on the gynaecology ward, 86 shifts were covered by bank or agency staff during that period. Registered agency nurses accounted for 25 of these shifts, whilst 26 shifts were covered by registered bank nurses. There were 35 shifts covered by bank healthcare assistants.

Medical staffing

- At the time of our inspection, there were no consultant obstetrician or gynaecologist vacancies and no use of agency or locum consultants.
- There was a consultant on call and anaesthetist available 24 hours a day, seven days a week for both maternity and gynaecology services. Out-of-hours cover consisted of one specialist registrar and one middle grade doctor for obstetrics and the same for gynaecology.
- During daytime hours, the usual medical cover was three doctors for obstetrics (consultant, specialist registrar and a junior doctor) and the same for gynaecology.
- As of June 2016, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust was lower than the England average.
- For obstetrics, the service operated a 'consultant of the week' system to cover delivery suite. Consultants allocated to this role had no other clinical commitments during the week of cover.
- The number of on-site consultant cover hours on delivery suite met the Royal College of Obstetricians and Gynaecologists (RCOG) guidance of 60 hours for a unit with 5000 births. The consultant obstetrician was resident Monday to Friday 8.30am to 9pm and non-resident 9pm to 8.30am on an on-call basis. On weekends, the consultant was resident 8am to 4pm and on-call 4pm to 8am. This meant that the service provided 78 hours of on-site consultant cover for delivery suite each week.
- The gynaecology ward had a 'consultant of the day' on duty from 8am to 5pm, then from 5pm overnight there were two consultants on call. During our inspection, we saw several doctors in attendance on the morning ward round accompanying the consultant gynaecologist and attending to patients' medical and surgical needs.
- There were two consultants for obstetrics and gynaecology available for emergency cases with flexible working between the departments to ensure even distribution of workload during weekends.
- Handovers between changing medical staff occurred at generally the same times each shift, however several senior and junior doctors told us and we observed that the format of handovers was inconsistent, lacking structure and at times chaotic within maternity.
- We spoke with several obstetric medical staff who told us that the dynamic of the medics was unusual because the some of the junior obstetricians although

experienced and competent, there was a lack of consultant leadership and ownership. Junior medical staff said that consultants were not always present on delivery suite although they were always contactable.

Escalation policy

- The trust had an escalation policy in place, designed to maintain safety during times of high demand and pressure such as staffing shortages, increased acuity and increased activity. We saw staff completing daily sheets to compare staffing against acuity and activity.
- The trust monitored how often the maternity escalation policy was triggered and data showed from January 2015 to December 2016 there were 49 occasions for delivery suite (at least three times each month), six occasions for the antenatal ward and four for the postnatal ward.
- The data did not record any occasions for the Wrekin MLU, however staff told us that midwives were frequently 'pulled' off the MLU to cover staff shortages elsewhere. They said staff were usually sent to work on delivery suite. Staff informally recorded this data in a diary and we counted 12 occasions from 13 November to 4 December 2016 when this occurred. This demonstrated the monitoring of this process was not robust. Midwives told us they escalated this with executive management in June 2016. Although they met with a senior manager for the trust, midwives felt no improvements had been made.
- The process for monitoring the maternity escalation policy was through maternity governance meetings. It was through this process that senior management developed a report to propose changes to the maternity services model in view of the increased activity at the consultant-led unit. The 'consultant unit risk' report in November 2016 outlined the risks and impact and proposed new staffing templates to ensure the trust provided safe care.
- The trust temporarily closed to maternity admissions in November 2016 for the first time in four years. This was to protect safety based on increased pressures within the unit. Staff told us they felt this was a relief and was the right thing to do for their patient's safety.

Major incident awareness and training

- The trust had a major incident policy. Some staff were aware of this policy and some could recall attending training.
- The trust had a child abduction policy within a security policy and a delivery suite member of staff told us the process was tested recently.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- We saw evidence-based care and treatment was provided and audited appropriately.
- A wide range of pain relief options were available to women supported by information to help them make informed choices.
- Information about the outcomes of women's care and treatment was collected and monitored.
- Breastfeeding initiation rates were above target at 71%.
- The service achieved and maintained level 3 'Baby Friendly' accreditation.
- Despite high levels of activity within the consultant led unit (CLU), the trust was achieving higher than average vaginal birth rates.
- The caesarean rates were below (better than) the trust and national targets.
- Staff were provided with support and education to be competent in their practice.
- Overall, there was effective multi-disciplinary work particularly in maternity theatres and gynaecology.
- Consent to care and treatment was obtained in line with relevant legislation and guidance.
- The trust had begun to collect and report data and outcomes for each MLU location as of December 2016.

However:

- Staff in all departments were below the trust target for appraisal.
- Antenatal triage was not a 24-hour service. This affected patient flow through the unit.
- Multi-disciplinary working in relation to handover was not consistently effective or robust.

Evidence-based care and treatment

- The service used a quality dashboard in line with the Royal College of Obstetricians and Gynaecologists' (RCOG) guidance.

Maternity and gynaecology

- Local policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and RCOG 'safer childbirth' guidelines.
- The trust employed a guideline midwife responsible for co-ordinating policies and procedures for maternity. Records for November 2016 showed 92% of guidelines were up-to-date and those that were out-of-date had action plans and were due to be presented at the next maternity governance meeting.
- The service had a non-clinical assurance co-ordinator, who was responsible for ensuring that all new standards and published guidelines were reviewed and implemented. A senior doctor told us and we saw in meeting minutes that all new NICE and RCOG guidance were reviewed and benchmarked against the trust's current policies and procedures. Records we saw demonstrated that managers reviewed and discussed this regularly in governance meetings.
- Care was delivered in line with the NICE Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy.
- Patients with risk factors for gestational diabetes were identified and offered glucose tolerance testing as recommended by 'Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK, 2015). This is a national surveillance programme for late fetal losses, stillbirths and infant deaths, and in line with the current NICE guidelines.
- The maternity service emphasised the importance of fetal movements to women by providing verbal and written information. This was in line with RCOG national guidance.
- We saw staff followed the policy regarding appropriate storage and disposal of pregnancy remains, and the policy was in line with the Human Tissue Authority standards issued in March 2015.
- An example of national guidance adherence was staff providing gynaecological patients with a leaflet based upon NICE guidance about treating women with heavy menstrual bleeding.
- A risk and needs assessment including gynaecology medical and social history was carried out, to ensure that patients had a flexible plan of care adapted to their own particular requirements in line with RCOG 2008 guidelines.
- The trust managed caesarean section procedures in line with NICE Quality Standard 32. This included detailed discussion with a consultant around choice of birth mode and debrief after the caesarean, with advice given for future pregnancies
- Staff told us had access to trust wide policies and procedures on the trust intranet. The staff we spoke with told us that they regularly received updates regarding changes to guidelines, and that these were accessible to them on the intranet.
- Nurses and midwives we spoke with were able to demonstrate their practice was evidence based. Staff could explain how they provided evidence based care. They told us they read updates sent out by the trust to maintain up to date knowledge.
- The care group planned an annual audit plan, which was developed to monitor the implementation of relevant NICE guidance. We saw evidence of the 2015/16 audit programme and monthly review of on-going audits in the quality and safety report and in multi-disciplinary monthly audit meeting minutes.
- We saw two examples of maternity clinical audits for induction of labour (November 2016) and anti-D prophylaxis (to prevent a potential autoimmune response) during pregnancy (October 2016). The anti- D audit results showed 100% compliance and the induction of labour audit was 79% overall when compared to NICE standards. This audit identified areas for improvements including re-auditing against local policy because of differences with NICE standards.
- The trust participated in research and development projects and from the care group's quality and safety report September 2016, we saw that nine maternity research projects were in progress.

Pain relief

- Within maternity, there was a wide range of pain relief available to women during labour which ranged from simple oral analgesia, water immersion, entonox (gas and air), and stronger medicine such as pethidine and epidurals.
- Postnatal women we spoke with told us their pain needs were addressed adequately during labour.
- Documentation we reviewed demonstrated a continuous assessment of patients' pain relief options whilst in labour.

- On delivery suite, we saw that information cards were visible in every labour room regarding the potential risks of having an epidural. This helped women to make an informed decision.
- Patients were able to access pain relief post-operatively in a timely manner. We saw staff offered pain relief frequently and patients told us their pain was well managed.
- We saw that within gynaecology, staff assessed pain and recorded this on the early warning score observation sheet. Patients we spoke with were satisfied with the pain relief they received.

Nutrition and hydration

- The trust had implemented the United Nations Children's Fund (UNICEF) 'Baby Friendly Initiative' standards for breastfeeding. They had achieved and maintained the highest level, 'level 3 baby friendly accreditation' since 2014.
- Data for November 2016 showed the trust's breastfeeding initiation rate was 71%, which was better than the trust and national target of 67%.
- The service had a specialist midwife with a strategic lead for infant nutrition with the role of providing staff training and carrying out audits.
- Staff supported parents who chose to formula feed their baby. The trust did not routinely provide formula milk but had stock available if parents did not bring their own. The unit had sterilisers if required, however parents were encouraged to bring ready-made formula for ease.
- Staff provided women with information about feeding cues and encouraged them to self-complete 'first week daily feed logs' to ensure babies were feeding regularly and to establish breastfeeding (if that was the chosen feeding method). We saw some completed feeding logs in postnatal records.
- On most of the maternity wards, a self-service trolley was available for women and their family to access hot and cold drinks.
- The patients we spoke with were satisfied that they had received adequate meals and hydration. Patients commented on the good quality and variety of the meals on offer.
- The units offered a wide range of meals and catered for special diets. Gynaecology patients had access to drinking water beside their bed unless they were nil by mouth. We saw staff serving hot drinks to patients several times during the day. Patients told us if they wanted a hot drink between usual serving times, they just had to ask and staff provided one.
- A nationally recognised malnutrition universal screening tool was used to screen gynaecology patients for their risk of malnutrition. We looked at nursing records and found that these were complete. We also saw that fluid balance charts were used appropriately to record fluid intake and urine output.

Patient outcomes

- In our 2014 inspection, we found that the trust did not have location level maternity dashboards, we saw they had been recently introduced at this inspection. The dashboards included maternal and neonatal outcomes and key indicators during pregnancy, labour and for each MLU.
- In 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030, with a 20% reduction by 2020. The trust had recently signed up to the 'sign up to safety' campaign to contribute to the NHS England ambition to improve maternity outcomes.
- The trust participated in some national benchmarking clinical audits such as 'Mothers and Babies: reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK), the NHS Digital national 'Maternity Services Data set' and the RCOG national 'Each Baby Counts' national quality improvement programme. An action was in place and was monitored by the trust's quality and safety committee.
- There were plans in place to commence participation in the NHS 'Saving Babies Lives Care Bundle' when funding secured from the clinical commissioning groups for scanning resources.
- From April to November 2016, the hospital had 3,349 births with 4,860 overall in 2015/16. The maternity dashboard data showed that 86% of all women booked at the trust for maternity care gave birth to their babies in the consultant unit. This rate was 82% for 2015/16 and therefore showed more women were choosing to give birth in the consultant unit. For 2015/16, 16% of women chose to give birth within one of the trusts' five midwifery-led units.
- The trust monitored and reported the percentage of women receiving one to one care during labour (one

midwife to one labouring woman) on the maternity dashboard. From April to November 2016, 98% of women received one to one care during active labour. The target was 100%.

- Year to date figures (April to November 2016) showed that the normal birth rate was 68%, which was within the locally agreed target range of 60-80% and better than the national average of 60%. The percentage for 2015/16 was 70%.
- From April to November 2016, the assisted birth rate (assistance required from a doctor to deliver the baby in instruments) was 11%, which was slightly worse than the locally agreed target of below 10%.
- The perineal third or fourth degree tear rate was 1.5% for the year to November 2016. The 2015/16 rate was 1.7%, which was better than the trust target of under 5%. The trust had begun to participate in research to look at factors affecting perineal trauma.
- From April to November 2016, the emergency caesarean rate was 11% with the average for 2015/16 of 10%. This was better than the trust target of 12% and better than the national average of 15%. The elective caesarean section rate for the same period was 10%, better than the trust target of less than 12% and better than the national average of 11%. The overall caesarean rate was 21% from April to November 2016, and for 2015/16 the rate was 19% which was better than the national average of 24%.
- Maternal smoking status at the time of delivery data showed that the trust had a rate of 16% from April to November 2016 and 15% for 2015/16, which was better than the locally agreed target of 20%.
- The percentage of women having their babies at home was 1.3% as of November 2016 and this was the percentage for 2015/16 overall. This was just below the national England average for home births of around 2%.
- The midwife to birth ratio from April to November 2016 was 1:30 and was in line with the recommended target of 'Birth-rate Plus'. The data provided was trust-wide and not broken down by individual unit.
- There were two maternal deaths from November 2015 to December 2016 and eight neonatal deaths during the same period.
- During the period 1 November 2015 and 1 December 2016, the trust reported 28 stillbirths with 18 preterm and 10 at term (over 27 weeks gestation). The main cause identified was placental insufficiency. No stillbirths occurred on the Wrekin MLU. The trust reported all stillbirths to the Confidential Enquiry into Stillbirths and Deaths in Infancy.
- From 1 November 2015 to 31 December 2016, there were 196 transfers from Wrekin MLU to the consultant-led unit, which included 183 for maternal reasons and 13 for neonatal reasons. The trust confirmed post inspection that they were not auditing transfers.
- In the 2015 National Neonatal Audit Programme (NNAP), the trust met or exceeded two of the NNAP standards or benchmarks and was below for two. There was no data to benchmark against the standard of the proportion of babies receiving their mother's milk.
- The trust monitored the number of term baby (over 37 week's gestation) admissions to the neonatal unit. Term babies should not routinely require neonatal unit admission. For 2015/16, 237 term babies were admitted. This was 5% of all babies born at the trust. A report detailed reasons for admission and proposed recommendations for improvement.
- Maternal readmission rates within 28 days of discharge averaged 1% from December 2015 to November 2016. For the same period, the rate for gynaecology readmission within 28 days was 7%.
- As of 29 September 2016, the trust reported one active CQC maternity outlier for maternal readmissions. This means outcomes from these procedures were outside NHS England's expected range. The trust told us this was not a true outlier and identified an issue with incorrect coding of mothers who accompanied their unwell babies who required readmission. Action taken was to change the coding process to ensure correct coding of neonatal admissions.

Competent staff

Maternity

- The service has a policy and procedure in place that set out the process for rotation of midwives in order to assist in supporting staff to gain experience in key areas of Midwifery and to refresh skills. A list of those rotating is produced every April and October. All midwives we spoke to had rotated within the past two years. We saw evidence of rotation rota's for 2017/18.
- Midwives were rotated from the MLU, we met a midwife who had just returned from working in the

consultant-led unit and she told us how much she had enjoyed her experience there and it had helped to update her skills. The service undertook a survey of midwives in May 2016, of the 213 respondents across all areas, 70% of midwives said they thought their clinical practice was enhanced.

- Data provided by the trust in November 2016 showed that 95% medical staff within obstetrics and gynaecology had an up to date appraisal. The trust set a target of 100% for all staff appraisals.
- Revalidation was part of the appraisal process for medical staff and was co-ordinated by the medical director's office. Staff we spoke with told us it was simple to arrange to have an appraisal completed.
- As of December 2016, maternity appraisal rates were 59% for the antenatal inpatient ward, 65% for delivery suite, 76% for Wrekin MLU, 92% for the postnatal ward and 94% for maternity outpatients. The care group monitored appraisal rates on a monthly basis and we saw evidence of this in the quality and safety reports.
- Staff we talked to said they had received an appraisal within the past 12 months. Ward managers told us they scheduled outstanding appraisals but clinical work took priority, which meant appraisals were cancelled and re-booked.
- Staff from all departments told us that development was encouraged and they felt supported by management, however time was an issue because of clinical time pressures.
- There was a structured induction programme for new members of staff to work through. All new staff were required to complete an induction booklet which was signed off by their line manager. Locum medical staff completed an induction package that managers were required to sign before commencement of employment. All newly qualified midwives received a preceptorship programme until they met specified competencies.
- The trust provided us post inspection with evidence of newly developed midwifery competencies for all employed midwives. This was to commence in February 2017 and we saw the agenda for this programme. This included the importance of midwifery competencies, accountability, implementation and monitoring of these competencies.
- Several midwives had undertaken the newborn and infant physical examination course so they could discharge low risk babies following birth. The framework within which they practised was clear and included a detailed list of neonates (babies up to 28 days old) they could review and those who needed referring to a neonatologist for discharge.
- The function of statutory supervision of midwives is to ensure midwives provide safe and high quality midwifery care, to protect the public. The nursing and midwifery council (NMC) sets the rules and standards for the statutory supervision of midwives. The Local Supervisory Authority report in June 2016 recommended the trust needed to improve the number of supervisory annual reviews because not all midwives had received one.
- All midwives had a named supervisor of midwives (SOM). The midwives we spoke with told us they had access to and support from a SoM and had an annual review within the past 12 months. They told us the process was very similar to the annual performance review and found this impartial support to be beneficial to discuss their practice.
- We spoke with several midwives who were supervisors. They told us several SOMs had stepped down from the role within the past year. This affected the number of midwives each SOM supervised and the trust responded by appointing a full time SOM to alleviate the pressure in the short-term. We saw this issue was on the maternity risk register and monitored on the maternity dashboard.
- The maternity dashboard showed the ratio of SOMs to midwives was 1:14.5 which was slightly better than the NMC recommendations of 1:15, despite the recent pressures.
- In October 2016, 'mental health first aid' training funded by the Child and Adolescent Mental Health Service Transformation Plan for Telford, Wrekin and Shropshire was provided to staff. Further sessions were booked for November and December 2016 and January 2017.
- Ward managers displayed information about the Nursing and Midwifery Council (NMC) revalidation requirements in staff areas and staff told us they understood these.
- The wards had a champion scheme where members of staff with an interest in a specific area, for example safeguarding, would receive additional training if required. They acted as a referral point, educator and source of knowledge for the rest of the team.
- We observed that WSAs and housekeepers positively challenged visitors to confirm their identity and to clean

their hands. Senior managers confirmed that these staff groups had received training to empower them to challenge visitors. We found this encouraged safety and hygiene in clinical areas.
- The maternity service had two trained midwife to perform neonatal frenulotomy (tongue-tie release) and had plans to fund another midwife in 2017 to expand the service.
- Within maternity outpatients, 16 midwife sonographers had received additional training in ultrasound scanning. Midwives told us they valued this opportunity and the trust was keen to offer this course for more midwives in the future. Midwife sonographers told us they received regular rotation between sites to maintain their skills and competence.

Gynaecology

- The gynaecology appraisal rate as of December 2016 was 67% and therefore below the trust target of 100%. We saw that managers discussed this in governance meetings.
- Within the gynaecology department, 90% of staff had received formal supervision.
- A gynaecology manager confirmed that they and six other nurses had completed sepsis training. However, there was not always a sepsis-trained nurse present on every shift within gynaecology.

Multidisciplinary working

Maternity

- We observed one example of poor communication between departments when a woman was transferred to delivery suite and it was evident the co-ordinator did not know where she came from or the reason for her transfer. The next day, we observed improved communication and handover from a different co-ordinator.
- Nursing and midwifery staff told us that there was an effective working relationship with medical staff and this included mutual professional respect.
- We observed midwives, nurses and medical staff interacting positively as a team in all clinical areas including the maternity theatre.
- GPs made direct referrals to both the gynaecology and maternity services and information was communicated back to the GP following discharge by letter.
- Copies of the birth summary were sent to the woman's GP and health visitor to inform them of the outcome of the birth episode.
- Midwives on the Wrekin MLU told us that paediatrician support was not effective when they required review of babies about whom they were concerned. They felt that the consultant unit was the priority and therefore paediatricians considered babies born on the MLU less of a priority.
- Staff told us the security service for the trust was supportive and they could contact them if they had any concerns for themselves or for their patients.
- The 'perinatal mental health' and 'safeguarding women with additional needs' meetings enhanced collaborative multi-disciplinary working both internally and externally.

Gynaecology

- Within gynaecology, the multi-disciplinary team included specialist nurses, gynaecologists, anaesthetists, theatre and recovery staff, GPs, physiotherapists, dietitians, pharmacists and bed managers. Staff described and we observed effective co-ordination to deliver the gynaecological services at PRH. This included effective communication with local GPs to ensure patients received the support they required when discharged.

Seven-day services

- A full team of staff including doctors, midwives, midwifery support workers and administration staff were available 24 hours a day, seven days a week for inpatient maternity services. This included a theatre team for out-of-hours emergencies.
- An anaesthetist was available 24 hours a day, seven days a week for women requiring an epidural during labour.
- The maternity service operated as a 24 hours a day, seven days a week service. Women contacted delivery suite or Wrekin MLU out of hours if they had any concerns or needed to attend in labour.
- The antenatal triage department was open seven days a week from 8am to 8.30pm. The trust initially piloted the service 24 hours a day but did not continue and reduced the opening hours. Staff told us this had a big impact on

the staffing capacity of delivery suite when triage closed because this meant all women were seen on delivery suite to be assessed. Managers told us this was under review to be placed on the risk register.
- A neonatal resuscitation team was available 24 hours a day, seven days a week.
- A supervisor of midwives was available 24 hours a day, seven days a week through an on-call rota system which ensured that midwives had access to a supervisor at all times.
- Out-of-hours pharmacy support was available on an on-call basis.
- Diagnostic imaging, including ultrasonography scans was available out of hours.
- The early pregnancy assessment service was open Monday to Friday, 8am to 4.30pm. This unit provided early scans and consultations for patients experiencing problems in early pregnancy up to 16 weeks gestation. The service also offered appointments on Saturdays and Sundays from 8am until 2pm.
- The gynaecological emergency assessment area was open 7am to 7pm, Monday to Saturday. A consultant gynaecologist was resident on the unit from 9am to 5pm, Monday to Friday and from 9am to 12pm at weekends.
- Consultant obstetricians, gynaecologists and anaesthetists were either resident on the unit or on-call 24 hours a day, seven days a week.

Access to information

Maternity

- When we asked a midwife to show us how she would find the transfer in labour policy, it took a considerable time to find it. This was because the actual name of the policy was required in the search field. This meant that staff could not access policies quickly or easily and this could be problematic if required quickly. Other staff said they found this to be an issue.
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- Staff information boards on the antenatal and postnatal wards included incident and complaints learning, maternity dashboard information and trust policy updates. The staff board on delivery suite displayed out-of-date information and was unorganised.
- We observed on delivery suite that there was open access to several staff computers. Staff told us each department had generic log in access but confidential and sensitive information was protected with individual staff access.
- Community midwives said that IT issues including network connectivity were an ongoing issue affecting their ability to work remotely. Executive managers told us this was a recognised issue and they were holding discussions to address the problem at trust level. We saw risk register meeting minutes for November 2016 that confirmed this.

Gynaecology

- On the gynaecology ward, an electronic system was in place as a visual display. This was known as the 'Patient's Statement at a Glance'. This gave health care professionals access to up to date information about each patient. Staff had access to electronic devices such as tablets to record and update patient observations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Maternity

- The trust had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, together with consent to examination or treatment policy.
- Records showed 72% of nursing and midwifery staff across the care group had received MCA awareness training, and 13% had received DoLS training. The target was set at 85% and therefore compliance was below this target.
- Consent forms for women who had undergone caesarean sections and instrumental births detailed the risks and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- Senior staff demonstrated good understanding of the MCA and DoLS. We saw there were clear templates to follow for assessment of capacity and there was a card available with a five-point assessment tool. A contact number was displayed for staff to obtain further information when necessary.

Maternity and gynaecology

- Patients gave informal consent for their care and treatment, and staff clearly documented this in patient records. We observed staff asking for consent prior to undertaking care procedures and observations such as blood pressure readings or fetal monitoring.

Gynaecology

- We looked at the records of patients experiencing pregnancy loss and saw that staff obtained appropriate consent to dispose of pregnancy remains.
- The trust's consent to examination or treatment policy supported patients' best interests, making this central to the process of obtaining consent. Staff utilised the Gillick competency assessment to assess capacity of young people (under the age of 16) to give consent for treatment such as termination of pregnancy. We looked at the assessment tool used by staff in the early pregnancy assessment service and saw there was a compulsory section for nurses to complete relating to Gillick competence.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Feedback from patients indicated that staff had a caring and compassionate approach.
- Women reported being treated with respect and dignity and having their privacy respected and dealt with in a sensitive manner.
- Women were encouraged to be involved in making informed decisions about their own care.
- People's emotional and social needs were highly valued by staff and embedded in their care and treatment.
- The maternity service provided bereavement support to women who experienced the loss of their baby. Additional support systems were in place to meet the women's emotional needs and family support.
- The Friends and Family Test score for November 2016 was above the England national average score in all aspects of antenatal, perinatal and postnatal care.

However:

- One woman us she had not received one-one care during labour and described being left alone for long periods, causing her anxiety.

Compassionate care

- Overall, maternity and gynaecology services feedback received indicated that staff had a caring and compassionate approach. Women reported being treated with respect and dignity and having their privacy respected and dealt with in a sensitive manner across this service.
- Between December 2015 and December 2016, the trust's Maternity Friends and Family Test (FFT) antenatal performance was generally better or similar to the England average. For December 2016, the trust's performance for antenatal care was 97% compared to a national average of 97%.
- Between December 2015 and December 2016, the trust's Maternity FFT birth performance was better than the England average. In December 2016, the trust's performance for birth was 100% compared to a national average of 97%.
- Between December 2015 and December 2016, the trust's Maternity FFT postnatal ward performance was better than the England average. In December 2016, the trust's performance for postnatal ward was 99% compared to a national average of 96%.
- Between December 2015 and December 2016, the trust's Maternity FFT postnatal community performance was generally better than the England average. In December 2016, the trust's performance for postnatal community was 100% compared to a national average of 97%.
- The trust performed similar to other trusts for 15 out of 16 questions in the CQC Maternity survey 2015. The trust performed better than others for patients feeling their length of stay in hospital was appropriate.
- The gynaecology ward FFT score for November 2016 showed that 100% of women would recommend the service against the national average of 96%. Trust scores in the CQC Woman's Experience of maternity services survey (2015) were the same as other trusts for all three indicators, with 145 women responding to this survey.
- All ward areas display boards featured 'thank you' cards from patients and families for the care they had received.
- Women described their care on the postnatal ward as 'fantastic' and the 'staff cannot do enough for you' despite being busy.

- Staff we spoke with demonstrated an understanding of the importance of respect for women's personal, cultural, social and religious needs.
- In maternity theatre, we observed staff giving compassionate care given to a partner who fainted.

Understanding and involvement of patients and those close to them

- Women told us that they were involved and in control throughout their pregnancy journey to identify what would make their hospital stay more comfortable.
- Women told us that they felt well informed and able to ask staff if they were not sure about something. Staff gave clear explanations in a way people could understand.
- Women felt listened to, understood and involved regarding choice of pain relief.
- Women were given the opportunity to make informed choices about the availability of birth settings that were appropriate and safe for their clinical needs and the risks involved.
- We spoke with several fathers who said they had felt included and involved as much as their partners had and well informed.
- Postnatal women told us they felt listened to regarding feeding choices and felt they received sufficient support and encouragement.
- Women waiting in the antenatal triage department said staff had kept them informed of any delays and the plan for their care.

Emotional support

- Women told us that they were supported by a consistent midwife during their pregnancy and received consistent advice and support.
- One postnatal woman told us she did not receive one to one care from a midwife during labour and described staff leaving her alone for long periods, which made her feel scared and affected her birthing experience.
- We observed effective emotional support from maternity theatre staff who helped women feel at ease and recognised that the theatre environment could be unsettling for them.
- There was an effective process in place to ensure the emotional and psychological wellbeing of pregnant and postnatal women was explored. Mental health questions were mandatory as part of the booking appointment and at intervals through the pregnancy.
- Maternity services had a specialist 'improving women's health' midwife who supported women living with mental health conditions during and after pregnancy.
- Midwife and clinical nurse specialists were available for gynaecology, colposcopy, diabetes, bereavement, provided support, and guidance to women and relatives.
- All women undergoing a medical termination of pregnancy were offered pre-termination counselling by a trained counsellor employed by the trust. Women who were anxious or unsure about their decision were provided with additional support.
- A specialist bereavement midwife supported women following a loss of a baby or bereaved parents experiencing a termination for medical reasons. The midwife offered support and advice to women and their families at specific stages, but was contactable if needed to support both staff through this difficult process and for women themselves. This support was also available at home if required. Information was provided detailing various agencies who provide counselling support for women and their families.
- On the early pregnancy assessment unit, staff showed us a box they gave to patients after a pregnancy loss; this contained a small teddy, a glass angel charm, a photo keepsake and words of comfort.
- A multi-faith chaplaincy was offered at the trust and women and their families were encouraged to access this service for emotional support.
- The trust had a 'Talk About' process where staff met with women post birth to discuss their experience if requested.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Services were delivered in a way that ensured demand was monitored and it met women's needs.
- Staff took into account the individual needs of women and their partners and ensured appropriate support was provided.

- Managers were in consultation to re-model maternity services to address the increased activity through the consultant-led unit.
- The service utilised available bed capacity at the five midwife-led unit (MLU) locations to help with PRH postnatal bed capacity.
- The service provided a sensitive bereavement service for women experiencing pregnancy loss, including specialist midwife provision, dedicated bereavement rooms and home visits as necessary.
- The supporting women with additional needs (SWAN) pathway was responsive to individual needs of women.
- Gynaecology incorporated breast surgery care to better integrate the care of women within the service.
- Complaints and concerns were taken seriously and regularly monitored; responses to complaints were appropriate and actively engaged the patient in service improvement. No complaints had been referred to the ombudsman within the reporting period for maternity or gynaecology.

However:

- Gynaecology beds were frequently filled with medical outliers, affecting gynaecology care access and flow.
- The environment of the Wrekin MLU was clinical in appearance and not the usual 'home from home' model.
- Staff told us they had not received learning disability training and felt their knowledge and experience was limited.
- Staff were not able to describe recent complaints or themes from complaints across the service.

Service planning and delivery to meet the needs of local people

Maternity

- The maternity service was undergoing a high-level review to improve maternity services across Shropshire and Mid-Wales. Senior midwifery managers identified the need for review based on 85% of birth activity occurring within the consultant-led unit despite the trust having the facility of five MLUs.
- Midwifery managers including the head of midwifery and the care group director developed a paper setting out revised potential care models in view of the increase in activity in the consultant-led unit and therefore reduced in the MLUs.
- The postnatal ward provided transitional care for babies who required special care such as antibiotics or regular observation monitoring, which put pressure on staffing capacity. The postnatal staffing template did not reflect the additional care required for transitional care. The ward manager on the postnatal ward had put a business case forward to increase staffing and planned enhanced training for staff to ensure adequate skills and competencies. The trust told us post-inspection that there were plans to develop a transitional care unit in line with national and regional network guidance.
- The maternity department had a day assessment unit, which was open from 9am to 5pm, Monday to Friday. GPs and community midwives could refer women to this service if there were any maternal or fetal concerns.
- The labour rooms on delivery suite were spacious and each had an en-suite bathroom.
- In contrast, the Wrekin MLU labour rooms were cramped and clinical in appearance. Midwifery-led units are based on a 'home from home' model with minimal clinical equipment to increase birth normality. Staff told us that they had proposed environmental changes but were restricted by the lack of funding.

Gynaecology

- The gynaecology unit had started to look after patients having breast surgery. Supporting breast patients formed part of the ongoing integration of services relating to women's health care.
- There were plans to develop a two-bed higher dependency service for gynaecology patients who required closer monitoring post-surgery to enable the ward to provide continuity in care and avoid an internal or external transfer. The gynaecology ward manager was trained in critical care nursing.

Access and flow

Maternity

- Bookings for pregnancy and birth at the trust were monitored to ensure demand did not exceed capacity. The maternity dashboard recorded the number of bookings for each month.
- For women using maternity services, the booking visit took place before 12 weeks of pregnancy. This included detailed obstetric, medical, mental health and social

risk assessments. Community midwives usually completed all bookings within the MLU's. The trust was actively liaising with GPs to ensure all women accessed maternity care before 12 weeks gestation.

- The trust had target of 90% of pregnant women booking for their maternity care no later than 12 weeks and six days gestation. This was to ensure women received optimum care and screening tests within designated periods. From April to November 2016, performance varied from 86% to 91% with the year to date figure of 89%. The trust met the target for 2015/16 with 92% of women booking within this time.
- Within maternity, staff met on the delivery suite in the morning and afternoon from all inpatient wards to discuss bed capacity, acuity and dependency and staffing levels to ensure communication and flow across the service.
- Staff told us that the introduction of the antenatal triage service since the last CQC inspection in 2014 had improved patient flow and delivery suite capacity. The service operated seven days a week during the hours 8am to 8.30pm.
- Between 1 November 2015 and 31 October 2016, there were 555 antenatal admissions and 1471 postnatal admissions to the Wrekin MLU. During the same period, there were 5381 admissions to the consultant led unit.
- The trust data from 1 November 2015 to 31 October 2016 showed the average length of stay for the consultant-led unit was 2.29 days and for Wrekin MLU 1.48 days.
- The service utilised the postnatal beds as often as possible by repatriating women from the consultant-led unit to an MLU that was closer to home. As well as improving the patient experience for women this assisted bed capacity on the postnatal ward.
- The antenatal ward staggered daily admissions for induction of labour at two-hour intervals with a total of five booked slots and two emergency slots Monday-Saturday. This was to assist patient flow and staffing capacity to designate adequate time to each woman.
- The average bed occupancy for maternity at PRH was 72% for 2015/16, above the England national average of 60%. Data for ward level bed occupancy rates from December 2015 to November 2016 was provided for the antenatal ward (38%), Wrekin MLU (23%) with delivery suite and postnatal wards combined (62%).
- Access and flow across maternity was discussed twice daily at the delivery suite 'board ward round', during which a senior midwife from each ward gave capacity and staffing details.

Gynaecology

- Gynaecology services had not met the indicator of 90% of patients waiting less than 18 weeks from referral to treatment time (RTT). The admitted RTT was consistently worse than the England average over the period December 2015 to December 2016. Month on month it was on average 10% lower than the England average with a consistent performance of 67 - 69% of patients seen within 18 week versus an England average of 79 - 82%
- In December 2016, the average wait time for gynaecology at the trust was 12.9 weeks, compared to an England average of 8.8 weeks.
- Woman who required urgent gynaecology treatment had a two week referral. The trust was achieving the 95% indicator for non-admitted RTT wait times with an average of 98% for the same period.
- Gynaecology operation lists ran three to four times weekly. The business manager monitored any cancelled operations. At the time of the inspection, there was one cancelled operation due to the patient being medically unfit for surgery.
- The business manager monitored the flow of patients through the gynaecology department. We met with a business manager who was visiting the ward to gather information about patient status from speaking with staff and looking at the 'patient safety at a glance' (PSAG) monitor. The business manager collected data and statistics and reviewed these at business meetings monthly.
- The gynaecology service created eight additional hysteroscopy clinics to help reduce patient waiting times.

Meeting people's individual needs

Maternity

- Maternity and gynaecology services delivered a range of specialist clinics for women. For maternity this included endocrinology and diabetes, perinatal mental health,

perineal trauma, anaesthetic review, postnatal pre-eclampsia follow up, haematology and infectious diseases. Gynaecology services included specialist clinics relating to oncology fertility and ambulatory care.

- The maternity service had an 'improving women's health' specialist midwife and the role included perinatal mental health and substance and alcohol misuse. There were also specialist midwives for teenage mothers.
- The supporting women with additional needs (SWAN) pathway was available for midwives to refer women requiring assessment for additional support. We saw the SWAN policy and referral process.
- The maternity service provided a tongue-tie assessment clinic and offered frenulotomy to babies with tongue-tie related feeding issues.
- Parent education classes were offered through the MLU's and was a collaborative approach with midwives and health visitors.
- Patients had access to informative literature. We saw information leaflets that staff gave to women during pregnancy, pre-labour and postnatally. An example was a perinatal mental health leaflet that promoted positive mental wellbeing with information of where to seek support. Staff could access leaflets in other languages from the hospital intranet for women who required them.
- We observed a staff member ensured that a non-English reading woman could make her food choices by getting the menu translated into her own language.
- A translation service was available for women whose first language was not English. Staff explained how the translation service was accessed and told us this worked well in practice. Staff told us that relatives were not used as interpreters for clinically related issues.
- The design and layout of ward areas offered patients privacy, comfort and in some cases access to private bathrooms and toilets. There were dedicated areas for women and families who had experienced the loss of a baby. These areas offered comfort and privacy.
- Staff used private rooms to deliver bad news to women and their families. Women experiencing pregnancy loss were cared for in side rooms on the gynaecology ward and there was designated rooms on delivery suite and the antenatal ward.
- Multi-disciplinary bereavement counselling clinic appointments were offered to all bereaved parents once all investigation results were received usually around three months post loss of a pregnancy loss.
- On the postnatal ward, any member of staff responded to call bells, not just the staff member allocated for the person's care. We observed call bells on both antenatal and postnatal wards responded to in a timely manner.
- We saw leaflets and posters displayed in many locations around the Women and Children's Centre and within ward areas for 'Kicks Count', a UK charity that aims to inform women about the importance of fetal movements during pregnancy. The leaflets had stickers on with the antenatal triage contact details, alerting women to call if they were concerned about their baby's movements. Reduced fetal movements can be an early sign of fetal distress and ultimately stillbirth.
- For patients with a learning disability, staff could access the learning disability link nurse and some staff were aware of reasonable adjustments to support these patients but not all. Staff told us they had not received training in this area and felt their knowledge and experience was limited.

Gynaecology

- The location of the early pregnancy assessment service (EPAS) unit meant that a woman with a suspected ectopic pregnancy could be directly referred for emergency assessment without having to leave the building. The unit was accessible via a designated entrance.
- Patients living with dementia were identified before or on admission. Gynaecology staff explained that information about the patient's specific needs would be included on the PSAG and the dementia care team would be alerted. The trust used a butterfly symbol to highlight patients with dementia care needs.

Learning from complaints and concerns

- Posters and leaflets about raising complaints or concerns were available in the wards and clinical areas we visited. These allowed members of the public to identify how they could raise a concern or make a formal complaint. We also saw 'comment boxes' to encourage patients and relatives to make comments or raise concerns which, where possible, could be dealt with locally.

Maternity and gynaecology

- A maternity patient experience report was produced each month for the maternity governance, women and children's care group meeting. The purpose of this meeting was to inform the governance group and centre board of the patient experience within maternity, including trends, themes and learning outcomes from complaints.
- We saw minutes of these meetings and confirmation that managers identified and discussed themes and learning from complaints. From talking to staff, it was clear that the process to systematically feedback learning from complaints to all staff needed improving. This was because not all staff were aware of themes of complaints for the service.
- Data for the period from December 2015 to November 2016 showed there were 16 formal complaints within maternity and 13 for gynaecology. The area that received the most complaints was gynaecology outpatients with nine received during this period.
- From November 2015 to October 2016, the patient advice and liaison service received 25 informal complaints for maternity services.
- There were no complaints referred to the Parliamentary and Health Service Ombudsman during November 2015 and December 2016.
- Staff gave examples of changes made in response to complaints. Postnatal ward staff gave an example of when Women's Services Assistants (WSAs) had their handover; they closed all room doors to ensure women did not overhear confidential information.
- A theme identified from the patient experience team was wait times for outpatient clinics and scans. We saw evidence of this theme discussion in the September 2016 maternity governance meeting minutes. Changes made in the short term included communicating wait times on a white board in the clinic, regularly updated by staff. The long-term plan included separating complex cases such as birth against advice as these take longer than the allotted time.
- Managers actively engaged with patients raising concerns or complaints to improve the service and we saw evidence of this in the maternity engagement group meeting minutes.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The maternity service was in a transition period of change and although new senior leaders had begun to make positive changes, we had concerns as to whether this service had an embedded safety and learning culture.
- Communication of incident learning was not consistently service wide or fed down to all staff. This meant that the service was not able to demonstrate they were a systematic learning organisation.
- Governance processes were under review at the time of our inspection. We saw evidence that although processes were in place, they were not fully embedded in the culture of the service.
- Senior management visibility was varied and staff felt overall local leaders were visible and support was sufficient but visibility of senior leaders varied.
- Staff morale on the Wrekin MLU was low because they felt they were constantly supporting the CLU, leaving the MLU vulnerable. Maternity staff felt 'battered and bruised' following a prolonged period of public scrutiny.
- Improved oversight of maternity services at all locations was required to strengthen team working, communication and governance processes.
- The service did not monitor outcomes, quality and safety at location level. This limits the opportunity to ensure that location specific issues were managed and addressed.

However,

- We saw improvements in the investigation of serious incidents including involvement of women and their families, implementing and closure of action plans.
- Quality and safety received sufficient coverage in senior managers' meetings and appropriate escalation to board level.
- The service was able to demonstrate compliance with the duty of candour regulation but did acknowledge improvement across the trust was required to strengthen evidence of compliance.
- Staff consistently felt supported, valued and listened to by local and divisional managers.

- Senior leaders acted immediately upon concerns raised during our inspection.
- The risk register was a living and active document that reflected current risks and concerns of the service and reviewed monthly.
- The senior leadership team demonstrated recognition of the issues within the service and explained plans to drive improvement including cultural change. They were in the process of addressing concerns and making changes in response to the recommendations from an independent review of an unavoidable baby death.
- Staff and managers at all levels recognised that the service was in a transition stage of improvement. All staff we spoke with expressed enthusiasm to improve the service.
- Managers were reviewing the maternity service model in response to the changed activity levels across locations.
- The trust was exploring what their supervision of midwifery provision would be for when it was no longer a statutory requirement in April 2017.
- The service engaged staff and the public to seek improvement in service provision.

Leadership of service

- The executive management structure composed of a care group director, a head of midwifery (HoM) and a care group medical director. The trust implemented the new triumvirate leadership formation to increase accountability and transparency within maternity services. Additionally, the management structure included a medical director for gynaecology, maternity, paediatrics and neonatal services respectively.
- The HoM and the care group director came to post in September 2016. All leaders within the triumvirate demonstrated passion and enthusiasm to drive improvement and recognised the areas that needed their focus including the culture of the maternity service.
- There was a lead midwife for community services (including all five MLUs), a lead midwife for acute service and outpatients and a lead nurse for the care group. Each MLU had a manager responsible for the day-to-day running of the unit and reported to the lead midwife. Although these management arrangements were in place to ensure joined-up working, we saw that the MLU's mostly operated independently of the consultant led unit.
- The Wrekin MLU manager had recently retired at the time of our inspection and a new manager had been appointed but not commenced in post.
- Overall, staff we talked to spoke highly of their local leaders and felt supported and able to raise concerns. Staff reported poor visibility of senior managers but were hopeful for change following the newly appointed HoM.
- Executive and senior leaders were able to identify previous issues within maternity including a lack of pace to embed a learning culture but had a clear strategy to drive improvement. They acknowledged that a sensitive approach was necessary to support staff through the changes.
- Both leaders and staff understood the value and importance of raising concerns. Staff we spoke with said they could approach the lead nurse or gynaecology manager about any issues on the ward. Managers and ward sisters demonstrated to the inspection team their desire and willingness to listen to staff.
- Overall, there was strong ward/unit level leadership and staff felt well supported.

Vision and strategy for this service

- We saw staff consistently delivered care and demonstrated behaviours in line with the trust vision and values. Staff could describe the trust values.
- Although some staff could not describe the future vision or strategy for maternity and gynaecology, they were aware that the service was in the process of change. Senior managers told us that maternity staff had experienced a prolonged period of external scrutiny, which had left them feeling 'battered', and were aware a sensitive and supportive approach was required moving forward. This meant senior managers were sharing information about change at a manageable pace.
- The gynaecology service had begun to support patients following breast care surgery as part of the ongoing integration of services relating to women's healthcare. Nursing staff had undertaken additional training to enable them to meet the wider or different needs that presented and there was consistent medical cover in place through a link consultant.
- The trust was exploring plans for supervision of midwifery models for when it is no longer a statutory requirement in 2017. The trust acknowledged the value

of supervision and we saw evidence in management meetings of discussions for future provision for midwives. Midwives we spoke with said they had an up-to-date annual review.

Governance, risk management and quality measurement

- There was a clear governance committee structure with direct reporting to the care group board. The terms of reference and membership had been recently reviewed to clarify responsibilities and to strengthen senior leaders' involvement. Sub-board committees reported to the care group with both non-executive and executive membership.
- The care group governance committee received regular reports on quality performance, patient experience, serious incidents, complaints, audits, risk register updates and infection control amongst other things. We saw evidence of this in meeting records.
- Concerns identified through this inspection including poor medicines management, non- compliance of the resuscitation equipment policy and unsafe telephone advice, we therefore had concerns as to whether the service was fully sighted on all current issues. This may indicate that governance and safety processes were not embedded.
- The care group managers had commissioned an external review of governance processes, which was in progress at the time of our inspection. Senior managers told us this was because they recognised there was potential to make improvements.
- Although we noted improvements since our last inspection in relation to perinatal mortality meetings, we noted from three meeting records that not all relevant managers attended these meetings such as the lead midwife for MLU's and community. This could mean missed opportunities to disseminate learning across the maternity service.
- The maternity service had recently introduced the Perinatal Institute's 'Standardised Clinical Outcome Review' tool to ensure comprehensive and standardised perinatal death investigations. This was following recognition that mortality reviews had not previously been adequately robust.
- The care group risk register was reviewed and updated monthly. We saw that the risk register identified and reflected the risks clinical staff were concerned about such as obstetric theatre resource and MLU IT system failures. Although maternity staffing was not currently on the risk register, we saw evidence of the risk assessment and that it was due to be discussed at the next risk register meeting. Risks and responsible owners were appropriately assessed, reviewed and escalated.
- The trust had begun a maternity dashboard for each of the MLU locations to collect, monitor and report outcomes, rolled out in December 2015. We saw this was an identified risk of the care group risk register.
- In September 2015, the trust commissioned an independent review into a baby death that occurred in 2009. The review made nine recommendations to the trust and reported a failure to embed a learning culture. Although trust failures were highlighted, it also identified considerable improvements in clinical governance and complaint processes following acceptance for accountability for the case. The final report from the review was presented to the trust board in April 2016 and a full and unreserved public apology was made by the Chief Executive to the family. Progress against the action plan drafted following the recommendations has been monitored by the trust's quality and safety committee and the trust board has had regular updates, as have the family involved.
- During this inspection, we found that the trust were taking these previous failures seriously and saw evidence of some changes taking place based on the independent review recommendations. The service recognised they were in a transition period and that continued improvements were required.
- The Local Supervisory Authority audit in June 2016 found that supervisor's' knowledge of governance processes for incidents triggering a supervisory review needed improvement. Senior managers acknowledged that midwifery supervision at the trust was going through a difficult period because of the aftermath of increased public scrutiny of maternity investigations, which affected the number of supervisors practising. Managers put in a short-term mitigation by having a full-time supervisor of midwives in post to address the shortfall.
- We reviewed five investigation reports, relating to the deaths of babies at the trust since our inspection in 2014. Although we could see that the investigations had been undertaken in a robust manner actions from some of the finding were not in a timely manner and not fully embedded in the service.

- The gynaecology manager explained they received monthly feedback from governance meetings and documented any pertinent information in a communication book for staff to read.

Culture within the service

Maternity

- All staff we spoke with said there was a strong drive to provide the best care and experience for all women, babies and their families.
- Senior leaders within the service expressed pride for the resilience of the staff and acknowledged that strong leadership was required to improve morale and culture. All staff we spoke with expressed a wish for stability within maternity services.
- Staff told us they felt there was an improved safety culture since the recognition of failures and they felt motivated to continue to improve. There was some evidence from our observations that this type of culture was not fully embedded. For example, the use of the maternity specific safety thermometer and checking of resuscitation equipment.
- Staff morale was low on the Wrekin MLU and all staff we spoke with told us this was because they felt their staffing establishment was used to cover the CLU. Several staff told us this left the MLU vulnerable and therefore staff felt vulnerable. Staffing issues was a consistent theme staff talked about throughout the maternity service. Senior leaders were actively seeking staffing reviews and scoping models of care to reflect the activity changes within the service.

Gynaecology

- Nurses and medical staff spoke positively about the care they provided for patients. Staff reported positive working relationships and we saw staff were respectful towards each other, not only within their area of work but across all disciplines.
- All the staff we spoke with in gynaecology were proud of their hospital and the service that they offered and thought that it was a very good place to work.
- There was a strong emphasis on promoting safety and well-being of staff and they told us they felt they were a strong team who supported each other.

Public engagement

- There was a quarterly maternity engagement group, which was a multi-agency meeting with a representative from the CCG, Healthwatch Shropshire, a supervisor of midwives, the HoM, the patient experience team and service users. We saw meeting minutes for September 2016 where patient experiences were shared and actions developed for areas of improvement.
- Following a serious incident, the trust conducted a local maternity survey in September 2016 to look at whether women who raised concerns during labour were taken seriously. Out of 394 postal surveys sent, 108 women (27%) responded of which 71 were medium to high risk during pregnancy and 37 women were low risk. Results showed that 88% of women felt listened to when they raised a concern during labour.
- The service took part in the Maternity Friends and Family Test. Results for November 2016 showed that 98% of women would recommend the service against the England national average of 96%. Response rates were low with 41 women taking part.
- The gynaecology ward FFT score for November 2016 showed that 100% of women would recommend the service against the national average of 96%. Thirty-five women responded out of 283 eligible patients.

Staff engagement

- Although each ward held ward meetings, staff told us that they found it difficult to attend due to clinical time pressures.
- We saw staff notice boards that communicated proposed service changes such as models of care and staffing structure review and how to increase patient flow and reduce transfers from MLUs to the CLU.
- Medical staff were encouraged to engage in the governance process by attending monthly meetings specifically for them and this was protected time outside of clinical duties.
- The care group director and some midwives told us about a recent staff engagement meeting held to gain staff views on how the service can improve. Fifty staff attended with a rolling programme for future sessions planned.

Innovation, improvement and sustainability

Maternity

- Newly appointed senior leaders were keen to drive improvement and arranged externally led workshops to explore the culture of the service.
- The trust was commencing participation in a research project to reduce perineal trauma during birth. This was to be locally led but discussed regionally with other trusts'.
- The on-going review of maternity services was considering the sustainability of all the MLU's across the trust.

Gynaecology

- Senior managers had provided 'collective leadership' workshops, which included human factors awareness, and planned to run more of these. Staff who had attended told us these were beneficial.

End of life care

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

Information about the service

The trust had an end of life care team, which consisted of the director of nursing and quality, an end of life care clinical lead, an end of life care facilitator and two nurses (job share) on secondment for six months.

A palliative care team provided a service from Monday to Friday, from 9am until 5pm. At weekends, the trust could contact the local hospice for advice on the telephone. The palliative care team consisted of four nurses, the local hospice partly funded two of the posts. Three of the palliative care nurses were based at the Royal Shrewsbury Hospital and one was based at the Princess Royal Hospital. At the time of our inspection, the trust was in the process of interviewing for a palliative care doctor and the trust had ensured funding was in place. The local hospice provided palliative consultant support.

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

The mortuary department was accessed via the main hospital and had storage for 30 deceased patients, including storage for three deceased bariatric patients.

The Princess Royal Hospital had a chaplaincy service and a multi-faith chapel on site for people who wished to pray. There was also a bereavement team on-site.

We visited the hospital's mortuary department and several wards that provided end of life care including the critical care unit and the dialysis renal unit. We also visited the chapel, the bereavement team and the medical device library.

During the inspection, we spoke with staff from the end of life team and the palliative care team, mortuary staff and staff on the wards caring for patients receiving end of life care. We spoke with four patients and reviewed 21 patient records.

End of life care

Summary of findings

We were concerned about infection control measures we saw in the mortuary department. We saw that the department was not visibly clean and tidy, there was no specific audit programme in place to monitor cleanliness, there were no arrangements in place for regular deep cleaning, surgical instruments were decontaminated manually and infection prevention training was not part of mandatory training for staff. We also observed mortuary staff not following trust infection control policy. We found a range of consumable items that were out of date

Doctors had not completed mental capacity documentation for defined ceiling of treatment decisions when the doctor had deemed the person as lacking capacity.

There was only one palliative care nurse at the hospital they did not have enough time to spend with patients or to always follow up on them. Staff from the palliative care and EoLC team were not up to date with mandatory training.

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

However, staff were highly motivated and passionate in providing EoLC and there was a drive for change and improvement. Staff at all levels and from all departments understood the importance of a dignified death. There was evidence of good working relationships across all areas of EoLC.

The trust had made EoLC one of its priorities in their 2015-2016 strategy and had an end of life steering group.

The trust had rolled out the Swan scheme across the hospital, providing resources for staff and practical measures for patients and families which included Swan boxes, bags and end of life information files for staff.

Funding for a full time consultant in palliative medicine had recently been approved. All staff had completed an appraisal within the past year.

Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an EoLC patient.

The trust took part in the national end of life care audit. The trust had taken a number of actions in response to the audit.

End of life care

Are end of life care services safe?

Requires improvement

We rated safe as requires improvement because:

- The storeroom was cluttered with items stored on top of the fridge. We found numerous items that were out of date in the stock cupboard in the mortuary's post mortem room. Expiry dates went as far back as December 1997. There was no stock control audits undertaken. However, we saw this had been addressed during our follow up unannounced inspection.
- Infection control measures were not fit for purpose. We saw that the mortuary department was not visibly clean and tidy. For example, we saw that the mortuary waiting area and taps, shelving, air vents and the floors in the post mortem room and storeroom were visibly stained and dirty. However, we saw this had been addressed during our follow up unannounced inspection.
- There were no arrangements in place for the regular deep cleaning of the mortuary, there was no specific audit programme in place to monitor the cleanliness of the mortuary; surgical instruments were decontaminated manually and infection prevention training was not part of mandatory training for staff.
- We observed mortuary staff not following trust infection control policy. We saw staff leave the post mortem room wearing their personal protective equipment and a member of the staff was not arms bare below the elbow as they were wearing a watch and bracelet.
- Staff in the mortuary department did not consistently record the deceased date of birth or age in the mortuary register.
- Equipment was unsafe. Staff used a broken hoist in the mortuary department, as the alternative hoist did not reach the top storage fridges. This was still broken on our return visit in January 2017.
- Staff from the palliative care and EoLC team were not up to date with mandatory training.

However:

- Nurses told us that they had no problems locating syringe drivers for people needing continuous pain relief.
- Staff in the mortuary department had a cleaning rota for day-to-day cleaning tasks in relation to cleaning equipment.
- Staff on the wards and the palliative care team washed their hands regularly and wore personal protective equipment.
- Hospital staff followed best practice guidance when administering controlled drugs.
- We found patient records contained relevant information, were legible, signed and dated.
- Staff knew whom to contact if they had any safeguarding concerns and could tell us the name of the safeguarding lead.
- Funding for a full time consultant in palliative medicine (with secretarial support) had recently been approved.
- There were processes in place for emergencies such as a pandemic, which mortuary leaders were aware of.
- All staff we spoke with knew how to report incidents and were encouraged to do so. Staff reported incidents on the trust's electronic recording system.

Incidents

- There were no never events or serious incidents reported by the End of Life Care service (EoLC) between October 2015 and September 2016. This may be because staff reported incidents under the speciality of which they occurred.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All staff we spoke with knew how to report incidents. Staff reported incidents on the trust's electronic recording system.
- There had been no incidents in EoLC that met the criteria for duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of the principles of duty of candour, such as being open and honest.

Cleanliness, infection control and hygiene

End of life care

- We visited the mortuary department and saw that not all areas were visibly clean and tidy. For example, we saw that the mortuary waiting area and taps, shelving, air vents and the floors in the post mortem and storage rooms were visibly stained and dirty. The storeroom was cluttered with items stored on top of the fridge. When we visited the mortuary unannounced in January 2017, we saw that this had been rectified the post mortem room had been deep cleaned.
- We saw a cupboard in the storeroom that was visibly water damaged. We asked staff how they would ensure the water damaged furniture was clean and they told us they could not.
- In the post-mortem room, we noted that mortuary staff performed cleaning tasks, such as cleaning tables and the floor after each post mortem. We reviewed several cleaning schedules and found them to be completed. However, there were no arrangements in place for the regular deep cleaning of the post-mortem room.
- We saw that one member of the mortuary staff was not 'arms bare below the elbow' as they were wearing a watch and a bracelet. This did not comply with the trust policy.
- We saw that mortuary staff wore personal protective equipment (PPE), such as aprons and gloves. We also saw there was a standard operating procedure (SOP) in place for PPE. We observed one member of the mortuary staff entering areas outside of the post mortem room in soiled PPE during a post mortem procedure.
- Staff told us that keeping the post mortem room floor clean was difficult due to the colour, as they were not always able to see any spillages including body fluids such as blood.
- We saw that the dirty and clean scrubs used by the mortuary staff were stored close together. This meant there was a risk of cross contamination from the soiled laundry.
- The hospital's policy was that anatomical pathology technicians did not complete post mortems when they identified high-risk neurological airborne infections, such as tuberculosis (TB) or Creutzfeldt-Jakob disease (CJD). In such instances, the technicians would arrange to transfer the deceased to a specialist centre where the post mortem could then take place.
- Staff completed post mortems on the deceased who had the human immunodeficiency virus (HIV). In such instances, they would only complete the procedure in the afternoon as the last post mortem of the day.
- We found that leaders in the mortuary did not complete hand hygiene or cleanliness audits.
- Mortuary staff decontaminated surgical instruments manually, which exposed staff to unnecessary risk and did not provide a high level of disinfection. Following our inspection the hospital arranged a visit from an infection control lead who recommended a washer disinfector to comply with HSE guidance.
- There were processes in place to record infection control risks when inputting details of the deceased onto the mortuary register. This was in line with the hospital's care after death policy. The mortuary register was a key record of deceased patients that staff logged into the mortuary. Staff were aware of the after death policy and could access the document in paper format or electronically.
- We saw there was a standard operating procedure in place for handling, storage and disposal of post mortem tissue.
- Patients and relatives we spoke with told us and we saw that staff caring for EoLC patients, were 'arms bare below the elbow'. They also told us they had seen staff washing their hands.
- We reviewed training records and found that all staff from the palliative care team had completed their mandatory training on infection prevention. However, infection prevention training was not part of mandatory training for mortuary staff.

Environment and equipment

- The hospital had not upgraded the mortuary department in many years, recent funding had gone towards improvements at the Royal Shrewsbury Hospital; however, a mortuary improvement plan had took place in 2016 when new chairs and pictures had been sourced. Staff told us that the fridges used to store the deceased were approximately 28 years old. We spoke with senior staff who told us that they did not have any problems with the refrigeration units malfunctioning.
- The storage capacity for the deceased was 30 spaces with three spaces available for bariatric patients. Staff told us that they had a contract with the local funeral director to keep additional storage spaces available.

Staff told us that if there were not enough bariatric spaces for the deceased, staff would arrange the transfer of the deceased to the undertakers or to the Royal Shrewsbury Hospital.

- The mortuary department had both adult and children's viewing areas. Families could go in the room with the deceased or view them through a window. A children's visiting room was added to the department in 2012; alongside a refurbishment of the waiting room.
- The external mortuary door had a keypad system in place. There was no internal swipe card access within the mortuary department. This meant that someone could accidentally enter restricted areas.
- We noted that mortuary staff kept a daily record of fridge temperatures. Staff tested and recorded fridge alarms on a weekly basis. Outside working hours there were processes in place to ensure that switchboard staff were alerted if temperatures went outside the acceptable range. We saw that switchboard staff sent emails to senior staff and estates when fridge temperatures were not in range.
- We reviewed the stock cupboards in the post mortem room and found numerous items such as bandages, needles, water for irrigation and histological specimens that were out of date. Expiry dates varied from 1997 to 2016. We also found opened bandages and broken mercury thermometers, the broken thermometers were stored in a glass jar. The mortuary department did not complete stock checks. When we visited the mortuary unannounced in January 2017, we found that all old stock had been removed.
- There was a process in place for when mortuary equipment was in need of repair. Mortuary staff sent requests to the estates department electronically and kept a copy of the request in the department.
- We saw that a hoist in the mortuary department had been broken since October 2016 and staff were still using this. Staff told us that there was not an alternative hoist that could be used as the other hoists did not reach the top storage fridges. Senior managers told us that the reason for the delay in fixing the hoist was due to awaiting new wheels as the wrong size were originally sent. This was still broken on our return visit in January 2017.
- We checked a range of equipment including syringe drivers and monitoring devices. The hospital had syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication. Nurses told us that they had no problems locating syringe drivers for people needing continuous pain relief.
- We visited the medical device library and found there were 12 syringe drivers available for ward staff. We saw that syringe drivers had been tested for safety and that tests had been completed within the required date. We also saw that staff from the department calibrated syringe drivers.
- The trust used a loan form and tracking system to ensure the return of syringe drivers. Staff in the medical device library told us that ward staff attached loan forms to discharge letters when syringe drivers were going into the community with a patient.
- Porters used trolleys to transfer the deceased from wards to the mortuary department. The trust had recently introduced a piece of equipment called an X-Cube, which was a three-dimensional frame with a cover to maintain patient dignity during transport to the mortuary. At this hospital, porters only used an X-Cube for children and the occasional bariatric patient. This was because the mortuary at this location needed to have an appropriate hoist in place before they could change practice.
- We saw that specialist mattresses were in place for end of life care patients requiring pressure relief.

Medicines

- Prescribing guidance for dying patients was available in the hospital's End of Life Plans and nursing staff knew where to find them. The plans were created to address the holistic needs of the dying person by providing supportive and compassionate person-centred care.
- The End of Life Plans contained information to guide staff on anticipatory prescribing. Anticipatory medicines are a small supply of medications for patients to keep at home just in case they need them; they can only be administered by a doctor or nurse. We saw the fast track checklist for EoLC patients listed four end of life drugs to discharge patients home with.
- The palliative care team nurses were nurse prescribers and could prescribe medications to patients. Ward staff told us the palliative care nurse visited the wards and prescribed medications to patients when required and that this had reduced delays.

- We reviewed the controlled drug register on a ward that provided EoLC and found nursing staff completed documentation appropriately. All medications we checked were in date.
- The palliative care team had developed a small information card on anticipatory prescribing in the dying patient. The cards were aimed at junior doctors and contained essential information, such as symptoms, dosages and medication types. The cards contained additional information such as accessing out-of-hour's nursing and medical advice from the hospice.

Records

- We found patients' records contained relevant information, were legible, signed, dated and mostly complete.
- The hospital had their own do not attempt cardiopulmonary resuscitation forms in place called "defined ceiling of treatment and allow natural death." We examined 19 defined ceiling of treatment and allow natural death forms, and found on the whole doctors completed them appropriately. However, we did see some gaps in recording for example, gaps in consultant signatures and the reason for the defined ceiling of treatment decision not being specific.
- We saw that the trust had carried out an audit of Defined Ceiling of Treatment and Allow Natural Death Policy in June 2016. The audit included both hospital sites (Royal Shrewsbury and Princess Royal Hospital).
- The audit identified 100% compliance with recording a defined ceiling of treatment decision on an approved form, good recording of patient details and the well-documented dates on decisions.
- However, the audit also found gaps in recording, a lack of evidence that the consultant had reviewed the original decision, and poorly documented discussions with the multidisciplinary team. The audit was due to be presented at the clinical governance executive meeting in January 2017.
- We visited the bereavement office and reviewed a death certificate. The doctor had completed the certificate appropriately.
- We saw mortuary staff kept a record of the deceased in the mortuary register. Details included names, jewellery, tray numbers and if there were any infections. Staff also recorded the deceased jewellery in a property book.
- We noted that staff were not recording the deceased's age or date of birth in the mortuary register. When we visited the mortuary unannounced in January 2017, we saw staff were recording these details
- We saw there was a process in place when two deceased patients had the same name. Staff colour coded the names in green and used a whiteboard to record this. Staff told us there was no specific same name policy.
- We reviewed mortuary records on organ tissue donation and found that staff had completed them appropriately.

Safeguarding

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

Mandatory training

- Palliative care, EoLC and mortuary staff had access to training sessions provided by the hospital. The palliative care team also had access to training provided by the hospice. Training was completed on line and face to face.
- We reviewed the training records provided and found that not all palliative and EoLC staff had completed all their mandatory training. For example, there was 0% compliance with conflict resolution training. The trust's target compliance rate for mandatory training was 100%. Mandatory training included subjects such as infection prevention, information governance, and equality and diversity.
- Mandatory training for mortuary staff consisted of moving and handling, equality and diversity, and information governance modules. One out of three (33%) of the mortuary staff had completed all their

mandatory training. The training that staff had not completed was fire training. The trust told us that they monitor compliance and that training leads contacted staff when their training was due to expire.
- The trust did not classify EoLC training as mandatory at the time of our inspection.

Assessing and responding to patient risk

- The palliative care team provided a five-day service, Monday to Friday where ward staff could contact the team for advice on deteriorating patients. During out-of-hours and weekends, staff could contact the local hospice for advice.
- Nurses on the wards we spoke with were aware of the palliative care team's role and felt they were responsive to requests for support.
- The palliative care team lessened the impact of the lack of service over the weekends by anticipating the patients who needed support and putting plans in place. Staff from the palliative care team told us they would review the patient and complete a plan with the ward if they felt a patient would deteriorate over the weekend, and inform the local hospice.
- Staff from the palliative care team told us that there was no set criterion when it came to reviewing patients. They aimed to review patients daily but used their professional judgement.
- Patients told us that staff showed them how to use the call bell; however, one patient told us that staff did not always leave the call bell within reach.
- We saw that nurses on wards caring for EoLC patients completed risk assessments on patients. For example, we saw nurses completed falls risk assessments and risk screening.

Nursing staffing

- The trust employed and funded a full time EoLC facilitator from September 2016. The EoLC facilitator worked one day a week at the Princess Royal Hospital and four days a week at the Royal Shrewsbury Hospital. There were 3.8 whole time equivalent (WTE) palliative care clinical nurse specialists working at the trust, one of whom worked mainly at the Princess Royal hospital. All staff on the palliative care team voiced a need for additional palliative care staff at the Princess Royal hospital.
- The palliative care nurse based at the Princess Royal Hospital was under increased pressure due to a rise in referrals. The palliative nurse told us that they had received 43 referrals in the last month, this was affecting the quality of service they provided. This was due to the limited time they were able to spend with patients and that they could not always follow up the patient. The palliative care team had no administrative support.
- Two nurses fulfilled a full time EoLC specialist role (job share). This was a secondment opportunity and was due to end in June 2017. The seconded posts were funded by Health Education England. The EOLC specialist nurses were based two days a week at the Princess Royal Hospital and three at the Royal Shrewsbury Hospital.

Medical staffing

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

Major incident awareness and training

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

Are end of life care services effective?

End of life care

Requires improvement

We rated effective as requires improvement because:

- We reviewed four defined ceiling of treatment forms for patients who had been deemed as lacking capacity and found consultants had not completed mental capacity documentation. This was supported by the trust's own audit findings.
- The trust scored below the national average on all five clinical quality indicators and met only one in eight of the organisational benchmarks set in the national End of Life Care Audit.
- The palliative care team only operated during weekdays within office hours, which meant that people did not receive the same level of service outside office hours.
- End of life care performance measurements were not part of the trusts dashboards.

However:

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

Evidence-based care and treatment

- The main reason for referrals to the palliative care team in n 2015-2016 was for assessment; other reasons included palliative care and supportive care.
- Data showed that the team reviewed and supported 247 patients at the trust with a non-cancer diagnosis between April 2015 and March 2016. Non-cancer patients accounted for 22% of the teams caseloads.
- The main reason for discharge of patients from the palliative care service was due to the referral being for clinical advice.
- Patients had their needs assessed and their care planned in line with evidence-based guidance, standards and best practice. For example, End of Life Plans and documentation for end of life care was in line with best practice from the Leadership Alliance five priorities of care 2014, 'One Chance to Get it Right' guidelines.
- The hospital ensured patients needing palliative care support were identified in a timely way and that the bodies of the deceased were cared for in a culturally sensitive and dignified manner. This conformed with the 'National Institute of Health and Care Excellence' (NICE) QS13: end of life care for adults (2011).
- A personalised end of life care plan was introduced after our last inspection in 2014, following the withdrawal of the Liverpool Care Pathway. The plan had been developed across all health services within Shropshire. It supported patients in the last few days and hours of life only.
- We only saw one End of Life Plan being completed at the time of our inspection; this may have been because none of the patients we saw had been identified as being in the last few hours and days of life. Staff kept copies of the plans on the wards and knew where to find them. One nurse told us that doctors were slow to use the plan and that they felt doctors were scared to use them.
- The trust took part in the End of Life Care Audit: Dying in Hospital (2016) which followed on from The Royal College of Physicians (RCP) published National care of the dying audit for hospitals in 2014. Following the audits, the trust had taken a number of actions. Actions included the implementation of a care after death policy and End of Life Plan, EoLC champions assigned to each ward and an end of life resource file for all wards.

Pain relief

- We reviewed two medication charts of patients receiving EoLC and found medication charts had been completed appropriately.
- The End of Life Plan provided a flow chart to guide staff on end of life pain relief. Staff kept the flow charts in resource files on the wards.
- Ward staff contacted the palliative care team for advice on pain control.
- Staff on the wards caring for EoLC patients showed us that pain was recorded on an electronic system.

End of life care

- One family member we spoke with told us that staff managed their relative's pain well and if they had needed more pain relief staff arranged this.
- The palliative care team responded quickly to support staff in pain management.
- We saw that the trust measured their delivery of pain management against the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015) and saw they achieved most of the standards. Of the standards not met actions had been identified. For example, the trust recognised that clinical nurse specialists in pain management should be able to prescribe independently and were in the process of organising a prescriber's course. All nurses on the palliative care team were nurse prescribers.

Nutrition and hydration

- The trust addressed the reduced need for food and drink in an information sheet for relatives. This information sheet was included in the End of Life Plan.
- Patients we spoke with were happy with the food provided by the trust. One patient we spoke with told us staff had supported them with eating their meals, another said they could have a cup of tea any time they wanted.
- We saw that staff made referrals to speech and language therapists when needed. We saw patients had fluid and hydration charts in place to monitor their dietary intake.

Patient outcomes

- We reviewed the results from the Royal College of Physician's End of Life Care Audit: Dying in Hospital, dated March 2016. The audit presents the results of the second biennial national audit of care of the dying in hospitals in England. At the time of participation (2015), the trust scored below the national result average on all five clinical quality indicators and met only one in eight of the organisational benchmarks set.
- At the time of our inspection (December 2016), we saw there was an action plan in place to address the findings of the audit and that the trust were working hard to improve EoLC. For example, we saw the hospital had implemented a bereavement survey and that the end of life facilitator was rolling out training on the End of Life Plan.
- End of life performance measurements were not part of the trusts dashboards. Senior leaders told us that the end of life care facilitator attended quality and safety committee meetings to share details of the national audit and to share the progress made by the EoLC and palliative teams.

Competent staff

- We found that the end of life facilitator had trained 1,729 clinical staff in EoLC planning up to December 2016. Approximately two thousand clinical staff still required the training.
- We saw that the end of life care team and the palliative care team attended and facilitated a number of training events. Courses attended included current issues in palliative care, dying matters, and an EoLC audit workshop.
- The trust held an EoLC conference in November 2015, which over 160 clinical staff attended. The EoLC lead clinician chaired the conference and subjects discussed at the conference included, "what is a good death?", and the role of the speech and language therapist in EoLC."
- Mortuary staff were trained on how to use hoists and equipment. Leaders trained porters and funeral directors and kept a record of this.
- The clinical lead for EoLC held a teaching session in May 2016 for medical, mortuary and bereavement staff. Topics involved registering a death, bereavement survey feedback and involvement of the coroner in the certification of death.
- Data showed that the trust had trained 10 out of 37 porters in the use of the new X-cube, a three-dimensional frame with a cover, used to transport deceased children from the wards to the bereavement suite.
- All of the palliative care team and all mortuary staff had completed an appraisal within the past year.

Multidisciplinary working

- Staff from the palliative care team attended regular multidisciplinary team (MDT) meetings in specialist areas such as brain, lung and cancer of an unknown primary (CUP).
- We observed a brain MDT meeting, which included a palliative care nurse, a consultant, an MDT co coordinator and a clinical nurse specialist. Radiologists and oncologists joined the meeting by video link. Referrals were discussed at the meeting and patients requiring supportive care were identified.

End of life care

- The trust had identified a lack of palliative medicine consultant at CUP multidisciplinary meetings as an operational challenge.
- We reviewed the hospital specialist palliative care team annual report 2016 and found CUP attendance by a palliative care consultant was 27%, which was significantly below the trust's target of 66% MDT attendance. The trust were interviewing for a consultant in palliative medicine who could attend future CUP meetings.
- We saw that the chaplain attended an eight weekly EoLC project meeting with the EoLC facilitator and nurses from the palliative care team. The team held the meeting to review progress in EoLC and to address any challenges faced.
- Palliative care staff discussed patient outcomes in weekly multidisciplinary meetings. The community palliative care team and the inpatient palliative care team attended each other's meetings on alternative weeks.
- Staff from all areas of the hospital that were involved in EoLC care spoke of a good working relationship with the palliative care team and knew the name of the EoLC facilitator.

Seven-day services

- The palliative care service was available Monday to Friday, from 9am until 5pm. The local hospice provided out-of-hour's support via the telephone.
- Mortuary services were available from 9am until 4pm, five days a week. Arrangements were in place for undertakers and porters to access the mortuary outside of these hours.
- The hospital chapel was open 24 hours a day, seven days a week for patients, staff and visitors. An on call number was available for chaplaincy services outside of working hours.
- A bereavement officer was available during normal office hours, Monday to Thursday 9am-5pm, Friday 9am-4.30pm.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed four defined ceiling of treatment forms where doctors had recorded patients as lacking capacity and found doctors had not completed the required mental capacity documentation.
- The trust completed an audit programme on the completion of defined ceiling of treatment forms in June 2016. The audit highlighted that in 90% of cases when the patient lacked capacity, the appropriate mental capacity documentation was not in place.
- Mortuary staff obtained consent prior to carrying out post mortems or tissue donation. Mortuary leaders kept records of consent in a file within the department.

Are end of life care services caring?

Good

We rated caring as good because:

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

However:

- Family members of EoLC patients we spoke with did not always feel that staff kept them informed.

Compassionate care

- The trust had implemented a bereavement questionnaire to relatives following the care of the dying audit 2014, which consisted of 21 questions. The trust issued 848 questionnaires between April 2016 and September 2016 and 183 people responded.

End of life care

- We reviewed the results from April to September 2016, which were mainly positive. For example, 89% of respondents felt that if they spoke to a doctor they were given adequate opportunity to ask questions and 89% felt that the hospital was the right place for their relative to spend their last days.
- We also reviewed bereavement feedback comments from families and friends and saw remarks such as, “We were only ever treated with kindness and compassion” and, “Our questions and queries were always dealt with.”
- Results from the survey also identified areas for improvement. For example, 67% of respondents said there was no discussion about where they wanted their relative to be cared for in their last days. Seventy-six percent of respondents said staff did not provide an information sheet following a discussion with staff about end of life care.
- We observed mortuary staff treating deceased patients with dignity, care and respect.
- We reviewed the care after death policy and found it contained detailed guidance for staff on the spiritual and religious needs of the dying patient. Staff from the mortuary department were aware of different faiths and what this may mean to them. We saw there was a cultural booklet available to all staff at the trust.
- Patients and families of patients receiving EoLC told us staff were polite and knocked on the door when they entered.

Understanding and involvement of patients and those close to them

- We spoke to two patients who were receiving end of life care and their families, one family knew who their relatives palliative care nurse was, the other patient did not know the name but told us the palliative nurse had been in to them to introduce themselves.
- Both family members we spoke with told us that staff did not keep them informed on what was happening. One family member told us they had not received an update for three days.

Emotional support

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

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There was no specific data on how many people had died in their preferred location or how quick discharge took place in EoLC patients.
- The hospital’s bereavement surveys showed delays in obtaining the medical certificate of cause of death as a concern.
- Sixty-seven percent of respondents in the trust’s most recent bereavement survey (April 2016 to September 2016) said there was no discussion about where they wanted their relative to be cared for in their last days.

However:

- The palliative care team were supporting increasing numbers of patients and referrals had increased by 22% from the previous year.
- We observed staff to be responsive to patients and their relatives. For example, staff from the bereavement office or the mortuary department would walk the relatives of the deceased to the mortuary department when they had arranged a viewing. Swan boxes and bags containing tissues, toiletries, jewellery and property bags were available to the recently bereaved.
- The trust had implemented a bereavement survey to gather peoples’ views on end of life care (EoLC).
- We visited the hospital’s chapel as part of our inspection and found it to be multi–faith. We saw information available for a variety of religions and that there was a Bible and the Quran.
- The mortuary department did not receive any complaints between December 2015 and November 2016.

- A complimentary therapist that worked alongside the palliative care team provided hand and foot massages in addition to aroma sticks to help with nausea and vomiting.
- The hospital chapel catered for patients of a variety of faiths.

Service planning and delivery to meet the needs of local people

- The hospital did not have a designated palliative care ward. Patients received EoLC in a variety of wards within the hospital. Ward staff alerted the palliative care team when a patient was identified that would benefit from their service and support.
- Ninety seven percent of people who responded to the trust bereavement survey (April to September, 2016) said they were given a bereavement booklet titled 'practical help and support for relatives and friends' following the death of a loved one.
- We reviewed the leaflet titled 'practical help and support for relatives and friends following the death of a loved one and found it contained a list of useful contacts for additional support.
- There was a quiet room called the Telford room, where families could attend to collect the death certificate. This room had a table and chairs and was next to the bereavement office.
- There was a chapel available to all patients, relatives and staff. Although mainly Christian dominated, the chapel contained information for people of a variety of faiths. The chapel had a sink area for washing and prayer mats were available.

Meeting people's individual needs

- The trust's EoLC draft strategy recognised the need to involve the hospital palliative care team in the care of patients with complex symptoms or other issues.
- Staff told us that if the bereavement office arranged a viewing in the mortuary they would walk the relatives to the mortuary. If the mortuary department was arranged the viewing they would meet relatives at the main entrance and walk them to the mortuary department.
- The mortuary had refrigerated viewing rooms. The adults viewing room was painted yellow and had a photograph of a butterfly on the wall. The children's viewing room had a cot in place and the room was large enough for a bed if needed. The children's viewing room had been designed by the children's department.
- Mortuary staff told us that there was no facility for families to wash bodies due to health and safety reasons. Mortuary staff could arrange for families to wash bodies at the funeral directors if they wished to do this. There was no standard operating procedure (SOP) in relation to this.
- The End of Life Plan contained a section for medical staff to record the patients preferred place of care.
- The trust had rolled out the Swan scheme across the hospital, which included Swan boxes, bags and end of life resource files for staff. The boxes contained information, toiletries, tissues, jewellery and property bags. A Swan bag was available for bereaved families in the accident and emergency department. This was because the trust felt a box would not always be appropriate if a patient's death was sudden.
- The hospital offered a remembrance photography service for families when they could be photographed holding the hand of the deceased.
- One staff nurse told us how there was limited private areas available when telling relatives bad news. The nurse told us that most of the time this was done at the patients' bedside.
- We visited the hospital's chapel as part of our inspection and found it to be multi–faith. We saw information available for a variety of religions and that there was a Bible and the Quran.
- The trust had a dementia service that consisted of a clinical nurse specialist and support workers. Volunteers at the trust were trained to be dementia buddies.
- A learning disability nurse was employed by the trust to support people with a learning disability.
- A complimentary therapist that worked alongside the palliative care team provided hand and foot massages in addition to aroma sticks to help with nausea and vomiting.
- Translation services were available 24 hours a day, seven days a week through a telephone service.
- One staff nurse told us how there was limited private areas available when telling relatives bad news. The nurse told us that most of the time this was done at the patients' bedside.

Access and flow

- Data showed that the palliative care team had supported 247 patients with a non-cancer diagnosis

between April 2015 and March 2016. This was an increase of 58 patients (22%) from the previous year. Non-cancer patients accounted for 22% of the palliative care team's caseload.

- The palliative care team took referrals from relatives, the local hospice and other primary and secondary health professionals. Ward staff could refer to the palliative care team by telephone, which meant that ward staff could contact the palliative team quickly.
- We reviewed the trusts specialist palliative care team annual report dated July 2016, and saw that the palliative care team saw the majority of patients (73%) on the same day as referral. A further 296 patients (24%) were seen within two days. Those seen within five days were usually due to a request from the referrer to delay first contact rather than a capacity issue.
- There was no specific data available from the trust on how many patients were able to die in their preferred location. The bereavement survey (April 2016-September 2016) asked family and friends if they felt the hospital was the right place to spend their last days following the patient's death. Out of 183 responses, 89% of family and friends replied yes and 11% said no.
- We saw that there was a fast track checklist available to staff. The checklist provided guidance to staff on what to consider when discharging an EoLC patient. Staff kept fast track checklists in end of life resource files on the wards.
- There was no specific data available on how quick discharge occurred in EoLC patients.
- The discharge liaison team supported patients requiring rapid discharge and occupational therapists became involved if there was a need for equipment. The palliative care team referred EoLC patients to the community palliative team following their discharge.
- The palliative care team arranged for the hospice at home service when a care package was not available. The hospice at home service supported patients in their last six weeks of life.
- Doctors verified deaths on the wards. Out of hours deaths were verified by the night manager. One staff member told us that there could be delays of up to five hours during the night. Death certificates were completed by doctors on the wards and families could collect these from the ward or the bereavement office.
- We noted that the trust identified delays in obtaining the medical certificate of cause of death as a theme within the bereavement survey. The EoLC facilitator had devised a flow chart and action plan as a result. An outstanding action was for mapping the process of obtaining the certificate to identify where the delays occurred.

Learning from complaints and concerns

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

Are end of life care services well-led?

Good

We rated well-led as good because:

- The trust had made end of life care (EoLC) one of its priorities in the 2015-2016 strategy.
- Staff at all levels and from all departments understood the importance of a dignified death.
- Results from audits completed by the palliative care team were presented at the clinical audit committee.
- The EoLC consultant was a member of the trust mortality group and gave feedback on the bereavement survey at its meetings.
- There was evidence that learning around EoLC was being shared with staff within the trust.
- There was a well-established EoLC and palliative care team in place.
- The trust had an end of life steering group who met every six weeks, which executive team members attended.

End of life care

- Staff were highly motivated and passionate in providing EoLC and there was a drive for change and improvement of EoLC services at the hospital. Staff we spoke to were positive about the EoLC service and felt it had improved.
- Staff felt supported by their immediate leaders.
- The hospital had recruited EoLC champions on wards who linked in with the end of life care facilitator.
- Staff were proud of the work they did and the trust recognised their achievements.

However:

- All risks evident in EoLC were not recorded on the trusts risk register.
- Staff at The Princess Royal Hospital did not feel they were as supported by the senior management teams as much as those who were based at the Royal Shrewsbury Hospital. Staff in the mortuary department felt uncertain about their future employment due to the restructures taking place within the service.
- Mortuary staff did not have regular team meetings where they could share any worries or concerns and meet with colleagues from the Royal Shrewsbury Hospital.

Leadership of service

- The end of life care management team consisted of the director of nursing and quality executive lead, an end of life care clinical Lead, an end of life care facilitator and a non-executive director (NED). The leadership team were based at the Royal Shrewsbury Hospital.
- The head of cellular pathology and microbiology oversaw the mortuary department.
- The trust had an end of life care steering group that met every six weeks and members of the executive team attended these meetings. Subjects discussed by the group included those highlighted in the Royal College of Physician's, End of Life Care Audit-Dying in Hospital March 2016, for example, the bereavement survey and staff training. The trust had appointed a lay member on the trust board with responsibility for EoLC. This was a recommendation from Norman Lamb in his letter to NHS trust chairs and chief executives in July 2013.
- The director of nursing sat on every committee within the trust and also sat on the trust board.
- There was no palliative care consultant at the trust, however, the trust had funding in place and interviews were due to take place.

Vision and strategy for this service

- We saw that the trust had a draft EoLC strategy in place. Senior leaders told us they were working towards a consistent strategy across Shropshire. The EoLC team's aim for the next five years included ensuring staff offered patients approaching the end of life in hospital a choice of where they would prefer to die, and to get better at considering advanced planning with patients who have life limiting conditions.
- We reviewed the trust's annual review document 2015-2016 and saw that the trust had made EoLC one of its priorities for that year.
- We found that staff at all levels and from all departments understood the importance of ensuring staff provided patients with a dignified death.

Governance, risk management and quality measurement

- We noted the mortuary department was licenced by the Human Tissue Authority (HTA) and displayed the certificate on the wall. Leaders told us that the next inspection was due in 2017 and that the inspection took place every three years.
- We saw that a member of the palliative care team presented findings from the EoLC audit 2015, to the members of the clinical audit committee in November 2016.
- Senior leaders told us there was no specific end of life risk register and that any risks would be included within the trust risk register.
- We reviewed the trust risk register dated February 2017 and saw that identified risks in the end of life service were not recorded. For example, there was no reference to the lack of a palliative care consultant or that there had been limited consultant cover at MDT's.
- We saw that leaders recorded potential and actual risks in relation to the mortuary department at the Princess Royal Hospital on the trust's risk register. For example, we saw that a potential risk had been considered, rag rated and actions and controls had been recorded.
- Actions included the provision of a business case for improvements. The risk was in relation to the moving and handling of bariatric patients who had deceased if proposed changes to the service went ahead. The risk

had an implementation date of March 2017 and a person responsible for the risk. There were no risks recorded in relation to the hospital mortuary despite concerns around infection control.
- The EoLC consultant was a member of the trust mortality group and discussed the bereavement survey at a meeting attended in November 2015.

Culture within the service

- We saw that staff were highly motivated and passionate in providing EoLC and there was a drive for change and improvement of EoLC services at the hospital. Staff across departments spoke of good working relationships with the EoLC facilitator and the palliative care team.
- Staff providing EoLC or following a death, felt they worked well together and that their immediate managers provided a good level of support.
- Staff in the mortuary department were uncertain what the future held due to the ongoing restructures within the department. This was leading to low morale within the mortuary team.

Public and staff engagement

- The hospital had recruited end of life champions on the wards. The champions linked in with the end of life care facilitator around end of life care.
- The trust recognised staff achievements, for example, we reviewed the trust board meeting minutes dated June 2016 and saw that the EoLC facilitator had received an award of recognition.
- We reviewed the End of Life Care Facilitator's 26-month highlight report 2016, which noted a plan to implement a staff questionnaire to gain information about EoLC support and training offered to staff, and any gaps in the service.
- The end of life care clinical lead gave presentations to senior medical staff at the doctor's essential education programme in 2016. We reviewed the presentation and found it contained information on what is a good death. The clinical lead provided senior staff with information about the bereavement survey, key messages and future developments.
- We saw there was a bereavement survey in place to obtain the views of the bereaved.
- Staff from the mortuary department told us they did not have regular team meetings and that it was rare they met with colleagues from the Royal Shrewsbury Hospital.

Innovation, improvement and sustainability

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

Outstanding practice and areas for improvement

Outstanding practice

- The palliative care team had developed a fast track checklist to provide guidance to ward staff on what to consider when discharging an end of life care patient.
- Staff told us that if the bereavement office arranged a viewing in the mortuary they would walk the relatives to the mortuary. If the mortuary department arranged the viewing, they would meet relatives at the main entrance and walk them to the mortuary department.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure there are sufficient nursing staff on duty to provide safe care for patients. A patient acuity tool should be used to assess the staffing numbers required for the dependency of the patients
- The trust must ensure ED meets the Department of Health's target of discharging, admitting or transferring 95% of its patients with four hours of their arrival in the department.
- The trust must review its medical staffing to ensure sufficient cover is provided to keep patients safe at all times.
- The trust must review the arrangements for the care of children in the emergency department to ensure it reflect the Royal College of Paediatrician standards
- The trust must ensure that it meets the referral to treatment time (RTT) for admitted pathways for surgery.
- The trust must ensure that up to date safety thermometer information is displayed on all wards
- The trust must ensure all theatre recovery staff have completed advanced life support training as per national guidance
- The trust must ensure all staff complete accurately paper and electronic records in a timely manner to document patient care and treatment, including early warning scores.
- The trust must ensure medicines are securely and appropriately stored at all times.
- The trust must ensure that midwives consistently prescribe medicines given in labour, in line with Nursing and Midwifery Council practice standards.
- The trust must ensure that mental capacity assessments are completed, when required in accordance with the Mental Capacity Act 2005.
- The trust must ensure they are preventing, detecting and controlling the spread of infections, including those that are health care associated in the mortuary department.
- The trust must ensure accurate monitoring of the maternity escalation policy for all areas including Wrekin MLU.
- The trust must ensure sufficient emergency equipment is available to respond to emergencies.

Action the hospital SHOULD take to improve

- The trust should ensure audits of adult prescription & administration records and adult 24-hour fluid balance charts are completed.
- The trust should consider using the maternity specific safety thermometer to measure compliance with safe quality care.
- The trust should ensure dying patients and their families and asked about their preferred place of death and that their wishes are recorded.
- The trust should ensure risks in relation to EoLC are recorded on the risk register.

Outstanding practice and areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met:** When a person who used services lacked capacity to make an informed decision, staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Need for Consent.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** How the regulation was not being met: Staff did not always assess the risks of people in good time and in response to people's changing needs. Regulation 12 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. **How the regulation was not being met:** Learning from incidents was not always shared and promoted within and between service specialties and across the trust to minimise the likelihood of reoccurrence. Regulation 12 (2) (b) HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

This section is primarily information for the provider

Requirement notices

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **How the regulation was not being met:** People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** There was not always sufficient numbers of suitable staff deployed to meet the care and treatment needs of patients. Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. **How the regulation was not being met:** Staff did not all receive statutory and mandatory training to ensure they were safe and competent to carry out their role. Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...