Experience Quality and Safety Committee

04 June 2020, 10:00 to 12:00
Board Room, Glasbury House

Agenda

1. Preliminary Matters

1.1. Welcome and Apologies

Oral

Chair

1.2. Declarations of Interest

Oral

Chair

1.3. Minutes of the previous meeting held on 16 April 2020 (for approval)

Attached

Chair

EQS_Item_1.3_Unconfirmed Minutes_16_April (AD).pdf (8 pages)

1.4. Matters Arising from Previous Meetings

Oral

Chair

1.5. Committee Action Log

Attached

Chair

EQS_Item_1.5_EQS Action Log_2020-21_Jun20.pdf (6 pages)

2. ITEMS FOR APPROVAL / RATIFICATION / DECISION

2.1. Clinical Quality Framework Implementation Plan

Attached

Chief Executive

3. ITEMS FOR DISCUSSION

3.1. Concerns & Serious Incidents Report

Attached

Director of Nursing

EQS_Item_3.1_Concerns and SIs Report.pdf (10 pages)

3.2. Update on Maternity Services, including: SATH Position

Attached

Director of Nursing

EQS_Item_3.2_SaTH Cover Paper.pdf (7 pages)

EQS_Item_3.2a_SaTH CQC Report.pdf (100 pages)

EQS_Item_3.2b_RSH CQC Unnannounced Feb 20 Report.pdf (24 pages)

EQS_Item_3.2c_PRH CQC Unnanounced Feb 20 Report.pdf (21 pages)

3.3. RCOG / RCOM Organisational Action Plan

Attached

Chief Executive

EQS_Item_3.3_Clinical Quality Governance Actions_May20.pdf (14 pages)

3.4. Clinical Audit Programme

Attached

Medical Director

EQS_Item_3.4_Clinical Audit Programme.pdf (26 pages)

3.5. Safeguarding Update

Attached

Director of Nursing

EQS_Item_3.5_Safegaurding Update.pdf (4 pages)

3.6. Infection Prevention & Control Update

Attached

Director of Nursing

EQS_Item_3.6_IPC Update May 2020.pdf (3 pages)

3.7. Risk Assessment: Transmission of COVID-19 in the workplace

Attached

Director of Workforce and OD

EQS_Item_3.7a_Risk Assessment - Transmission of COVID-19 in the workplace.pdf (7 pages)

EQS_Item_3.7b_Appendix 1_BAME Staff.pdf (3 pages)

EQS_Item_3.7c_Appendix 2_Risk Assessment COVID-19.pdf (10 pages)

3.8. Support to Care Homes during COVID-19

Attached

Director of Nursing

EQS_Item_3.8_Care Homes.pdf (6 pages)

4. ITEMS FOR INFORMATION

There are no items for inclusion in this section

5. OTHER MATTERS

5.1. Items to be Brought to the Attention of the Board and Other Committees

Melanie Davies

5.2. Any Other Urgent Business

Melanie Davies

5.3. Date of the Next Meeting: 30 July 2020, Board Room, Glasbury House, Bronllys Hospital

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 16 APRIL 2020 VIA SKYPE MEETING

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Vivienne Harpwood	PTHB Chair
Owen James	Independent Member
Frances Gerrard	Independent Member

In Attendance:

Carol Shillabeer	Chief Executive
Alison Davies	Director of Nursing and Midwifery
Julie Rowles	Director of Workforce, OD and Support Services
Stuart Bourne	Director of Public Health
Wyn Parry	Medical Director
Claire Madsen	Director of Therapies and Health Sciences
Rani Mallison	Board Secretary

Apologies for absence:

Susan Newport	Independent member

Committee Support:

Stella Parry	Committee Secretary

EQS/20/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Vice-Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/20/02	**DECLARATIONS OF INTERESTS** No interests were declared.

EQS/20/03	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 4 FEBRUARY 2020** The minutes of the previous meeting held on 4 February 2020 were AGREED as being a true and accurate record pending the following amendments: • Typographical errors to be corrected.
EQS/20/04	**MATTERS ARISING** EQS/19/88: Owen James queried whether the amendment to the Committee Action Log to include an additional column stating the due date had been progressed. The Board Secretary agreed to progress this work but noted that Committee Chairs would have to be clear on timeframes at the time of raising actions. This would be discussed further with Independent Members outside of the meeting. EQS/19/90: The Chief Executive reported to the Committee that the CQC report regarding Shrewsbury and Telford Hospitals NHS Trust (SaTH) had been published. A summary of the findings would be provided to the Committee under Any Other Business.
EQS/20/05	**COMMITTEE ACTION LOG** In light of the COVID-19 pandemic it was agreed that action would be reviewed and prioritised for the duration of the period. Work had been undertaken with the Board on how it would demonstrate its priorities during this time. It was noted that Priority 1 would be progressed during the COVID-19 period, Priority 2 would be progressed at the soonest available opportunity and Priority 3 would progress once business as usual was resumed. The Chief Executive provided the following update on prioritisation in line with COVID-19, the Committee noted that the update was an initial judgement and would require further discussion and ratification from other Executives. EQS/19/89: It was confirmed that assurance had been received via revalidation and CPD. Priority 3 was suggested. EQS/19/76: Work had been undertaken regarding possible learning from COVID-19 and how PTHB could work differently. Priority 2 was suggested. EQS/19/75: It was noted that some Clinical Audit's such as Critical Care areas would be suggested as Priority 1 whilst others would be Priority 3. EQS/19/75: The group was assured that Ophthalmology would be reviewed as some eye services would continue as

	Priority 1. This will be discussed further under agenda item 3.1b. EQS/19/74: Information Governance response remains a Priority 1 provision. An update report would be provided at the next meeting. EQS/19/73: Some areas would be considered Priority 1, update reports would continue to be received. EQS/19/72: It was noted that Mortality Reviews will need to be undertaken for both COVID-19 and Non-COVID-19 patients. However, a robust mechanism would need to be established to enable this during a period on intense pressure for frontline staff. It was agreed that the Chief Executive would discuss this with the Clinical Executives to establish as Priority 1 or 2. EQS/19/71: The Director of Nursing noted that HIW had stood down the regulatory inspection of Maternity Services in Powys, however, PTHB were in regular contact with commissioned services providers and were monitoring provided services. EQS/19/68: It was noted that this item was not yet due and would be assessed as an important piece of work. The Committee was informed that the Annual Quality Statement submission had been deferred until September 2020. EQS/19/22: It was confirmed that due to pressure on the Estates department this item would likely be a Priority 3. A further assessment would be made by the Board when reviewing the Capital Programme for 2020/21.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
There are no items for inclusion in this section.	
ITEMS FOR DISCUSSION	
EQS/20/06	**CORONAVIRUS (COVID-19):** *A) OVERVIEW* The Chief Executive provided an overview of the development regarding COVID-19 to the Committee. It was reported that there had been a need to reprioritise, plan, prepare and implement. A 5 point plan had been approved by the Board on 25 March 2020. The health board would be addressing key outstanding areas and the risks held. Some of the key areas of risks were highlighted to the Committee and would be discussed in more detail under agenda items 3.1b-g. It was noted that a COVID-19 risk register had been developed and was due to be updated in the style of the Corporate Risk Register.

B) NON-COVID-19 ACITIVITY

The Chief Executive reported that the initial duration of the COVID-19 period had been estimated at 6 weeks, this had been adjusted to a longer period likely to last several months. Due to this development Dr Catherine Woodward has been commissioned to develop a document regarding mechanisms for planned and non-urgent care. An assessment would be made of areas in which short term actions are required to avoid possible harm and recommendations for action would be developed including management arrangements.
The Assistant Director of Commissioning was working with secondary care providers such as WHSSC and a Clinical Leadership Group has been developed. The work to be undertaken regarding the mechanisms for planned and non-urgent care would be available in the coming weeks and would be shared with the Committee.

C) *STAFFING OF THE CLINICAL RESPONSE MODEL*

The Director of Nursing presented a paper and requested that the Committee:

- Ratify the approach being taken to staff the clinical response model
- Note Welsh Government's position in relation to the Nurse Staffing Levels (Wales) Act 2016
- Ratify the recommendation that the Annual Report due in May 2020 as a requirement of the Nurse Staffing Levels (Wales) Act 2016, is indefinitely postponed.

Owen James queried the provision of ITT Nurses to Aneurin Bevan University Health Board (ABUHB). The Director of Nursing highlighted the principle of mutual aid and noted that potential risks had been considered by the Executive Team with the focus of balancing risk throughout Wales.
The PTHB Chair raised concerns regarding newly qualified staff being utilised and the possible mental health implications of the pandemic on staff mental health. The Director of Nursing assured the Committee that the impact on newly qualified staff was to be mitigated through training, orientation and ongoing support. The Director of Workforce and OD confirmed that mitigations in place for managing staff wellbeing would be discussed under agenda item 3.1e.
Frances Gerrard queried whether progress had been made regarding Student Volunteers. The Director of Workforce and OD confirmed that progress had been made both locally and with the national HIEW programme.

The Committee RATIFIED the approach being taken to staff the clinical response model and the recommendation that

	the annual report due in May 2020 as a requirement of the Nurse Staffing Levels (Wales) Act 2016, is indefinitely postponed. The Chief Executive noted that both areas would be kept under review. D) *PPE ARRANGEMENTS* The Director of Public Health reported that work had been undertaken regarding stock, supply chain management, distribution and strategic and governance arrangements for PPE. A Centralised Hub had been implemented in Bronllys for PTHB. An overview of the PPE stock held by PTHB as of 5th April 2020 was provided: • 99,000 Fluid Resistant Surgical Masks • 7,000 Visors and goggles • 1,200 Gowns • 6,200 FFP3 face masks Demand modelling for PPE has been undertaken by PTHB and modelling had been received from Welsh Government. The Welsh Government model suggests that over the course of the COVID-19 pandemic 500,000 FFP3 face masks would be required. Supplies are being provided on a continuous basis to the 6 main sites in Powys (including 10 wards) as well as MIU's, midwives, mental health, district nurses and X-Ray radiography departments. A generic PTHB COVID-19 email account has been established and any requests for PPE outside of the aforementioned areas are handled by this account accordingly. The Strategy for PPE includes the following 3 areas: • Reduction in demand (sessional use, bundling of care) • Rational and appropriate use in line with national IPC guidance • Co-ordination of supply chain It was reported that the Military had been supporting PTHB on logistics and a weekly PPE co-ordination group had been developed with a provider focus. A virtual PPE team had also been developed. The Director of Public Health advised that Public Health bodies in the UK had confirmed sustained community transmission in the previous week which had implications for the use of PPE. The Committee was assured that PPE continues to be a focused area of work. Owen James queried whether a mutual aid agreement had been agreed for PPE across Wales. The Chief Executive noted that mechanisms are to be discussed and established by Welsh Government.

E) *STAFF WELLBEING & SUPPORT ARRANGEMENTS*

The Director of Workforce and OD provided a presentation regarding Staff Wellbeing and noted that the current period is a testing and uncertain period for staff.
The presentation provided a summary of:

- Support arrangements in place:
  - Daily bulletin
  - Silvercloud available without referral
  - Regular meetings with Trade Unions
  - Occupational Health Wellbeing Hub
- Support arrangements under development:
  - Links with the Citizens Advice Bureau
  - Expanding counselling provision
  - Short surveys
  - Charitable Funds support

The Vice Chair noted the activities of the work stream and expressed that thanks be passed to all staff on behalf of the Committee. Owen James raised that the Charitable Fund had identified potential to add value through support. The Committee welcomed the confirmation that the Charitable Funds Manager had commenced in post.

F) *ETHICAL FRAMEWORK*

The Medical Director reported to the Committee that the Ethical Framework had been published and had been adopted by all Ethical Committees in Wales. It was agreed that the Medical Director would circulate the framework post-Committee to Independent Members for information.
The PTHB Chair advised that she had drafted a paper which provided a resource document regarding ethics and would share this with members post-Committee.

G) *CLINICAL DESCISION MAKING*

The Medical Director provided an update and noted that the 3 core principles of the framework would be underlined by what care would be provided in Powys, how it would be provided and how it would be provided safely. It was noted that this would be challenging for Powys as there are little secondary care resources or staff available.

It was suggested that the role of Powys would be to support and provide step-down care to COVID-19 and non-COVID-19 patients. The challenge would be defining those patients who are to receive care within the PTHB Community Hospitals.

	All principles in the framework had been based on the Ethical Framework and the Medical Director expressed that equity of care must be carefully considered. It was noted that supporting the rehabilitation of patients is a strength in Powys and the health board should remain fluid on the type of patients that are cared for within its community hospitals. The Medical Director confirmed that when a definition of what care is provided in Powys and which patients are to be treated in the Community Hospitals was received the framework would near completion. The Chief Executive raised that work was ongoing into the Clinical Decision Making to ensure risks are mitigated without compromising the level of care provided. It was noted as essential that the pathway, risks and monitoring had been appropriately assessed. It was AGREED that when the Clinical Decision Making had been approved by the Gold Group an update would be provided to the next available Board Briefing.
ITEMS FOR INFORMATION	
There were no items for inclusion in this section	
OTHER MATTERS	
EQS/20/07	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be reported.
EQS/20/08	**ANY OTHER URGENT BUSINESS** The Chief Executive provided the following update regarding the CQC review into SaTH: • The report has suggested an overall rating of inadequate • Inadequacies have been identified in a range of areas including caring and safety • SaTH continues to be in special measures • Executive to Executive meetings would continue during the COVID-19 period. It was AGREED that a more in-depth discussion would be held by the Committee on 4th June 2020. The Vice Chair expressed her thanks to Executives for the levels of work that had been undertaken so far during the COVID-19 period.
EQS/20/09	**DATE OF THE NEXT MEETING**

	4th June 2020, 10:00am – 01:00pm, Board Room, Glasbury House, Bronllys Hospital

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Arising from Meetings of the Experience, Quality & Safety Committee (2019/20)					
EQS/19/89	4 February 2020	Information regarding how PTHB receive assurance that visiting clinicians are compliant with training will be circulated with Committee Members.	Assistant Director of Quality & Safety	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q4, 2020/21 (priority 3).	
EQS/19/76	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

EQS/19/75	3 December 2019	The Item Clinical Audit Plan & Update on Progress is requested to return to the Committee within a short timescale	Medical Director	16 April 2020 The Committee agreed that in light of COVID-19, that some elements of clinical audit would need to be a priority and others deferred. It was agreed that a Clinical Audit Plan would come forward to the Committee on 4th June 2020. 04 February 2020 It was agreed that the item would return to the next meeting of EQS on 2 April 2020.	
EQS/19/75	3 December 2019	Discussion around the National Ophthalmology Audit (Adult Cataract Surgery) will take place at QGG.	Medical Director	16 April 2020 It was agreed that this audit would be considered when developing the Clinical Audit Plan.	
EQS/19/74	3 December 2019	Future Information Governance Quality reports will include further analysis and benchmarking	Board Secretary	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

EQS/19/73	3 December 2019	A Health and Safety Report Update will be brought to the Committee in the next 6 months	Board Secretary/Director of Workforce & OD	16 April 2020 Some areas would be considered COVID-19 Priority 1, update reports would continue to be received.	
EQS/19/73	3 December 2019	The 'Heat Maps' reported to the LPF will be provided to this Committee at the next Health & safety Update report	Director of Workforce & OD	16 April 2020 To be included in Health & Safety Updates, as above.	
EQS/19/72	3 December 2019	From January 2020 quarterly in-patient mortality reviews will take place, a Q3 review will be brought to the Committee on 4 February 2020	Medical Director	16 April 2020 The Committee agreed that in light of COVID-19, this action would need to be a priority for Q1, 2020/21 (priority 1). 04 February 2020 Q3 information would be available end of March and a substantive item brought to Committee April 2020	

EQS/19/71	3 December 2019	The Committee will continue to monitor the Maternity Assurance Framework periodically	Director of Nursing & Midwifery	16 April 2020 HIW had stood down the regulatory inspection of Maternity Services in Powys, however, PTHB were in regular contact with commissioned services providers and were monitoring provided services.	
EQS/19/68	3 December 2019	An Annual "Putting Things Right" Report will be brought forward to this Committee in June 2020	Assistant Director of Quality & Safety	16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3-4, 2020/21 (priority 3).	

EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be confirmed at the next meeting	Assistant Director of Estates and Property	<u>16 April 2020</u> It was confirmed that due to pressure on the Estates Department as a result of COVID-19, this item would be deferred to Q3, 2020/21 (Priority 3). A further assessment would be made by the Board when reviewing the Capital Programme for 2020/21. <u>03 December 2019</u> The immediate improvement work identified in the HIW report is now complete however it is recognized that further work is required. This item is currently being assessed by the Capital Control Group and the mechanism of prioritization which will be brought to the Board on 29 January 2020 along with the Capital Programme for sign-off. <u>10 October 2019</u> There is an ongoing	

				discussion with Welsh Government around potential further capital funding to support refurbishment work at the hospital, which would include The Hazels and other adjacent houses; timescale not agreed. In the meantime, work has been undertaken to upgrade a toilet in The Hazels but it is recognised further work is required.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.1

EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 4 JUNE 2020**
Subject:	**Concerns and Serious Incidents Report**
Approved and Presented by:	Alison Davies, Director of Nursing
Prepared by:	Rebecca Membury – Senior Manager, Putting Things Right Wendy Morgan, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:
This report provides the Experience, Quality and Safety Committee with an overview of performance in Concerns and update on the reporting and investigation of serious incidents, current assurance position, summarising lessons learnt and good practice.
RECOMMENDATION(S):
The Experience, Quality and Safety Committee are asked to DISCUSS this report and NOTE the actions underway to address areas of non-compliance and where further improvement is needed.

Approval/Ratification/Decision	**Discussion**	**Information**
X	✓	x

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper provides the Experience, Quality and Safety Committee with assurance in regards to the current position in managing concerns and serious incidents.

The total number of concerns, informal and formal, the last quarter of the year reflect the monthly average received whilst the overall total for 2019-2020 show an increase in formal concerns received compared to informal concerns. Closure of formal concerns within 30-working days achieved 47% against a target of 75% and there has been ongoing activity during this time focussed on closing formal concerns that have exceeded the 30-working day response timeframe. Response rates for informal concerns show 73% compliance against an internal target of 90% impacted by changes in response timeframes in year.

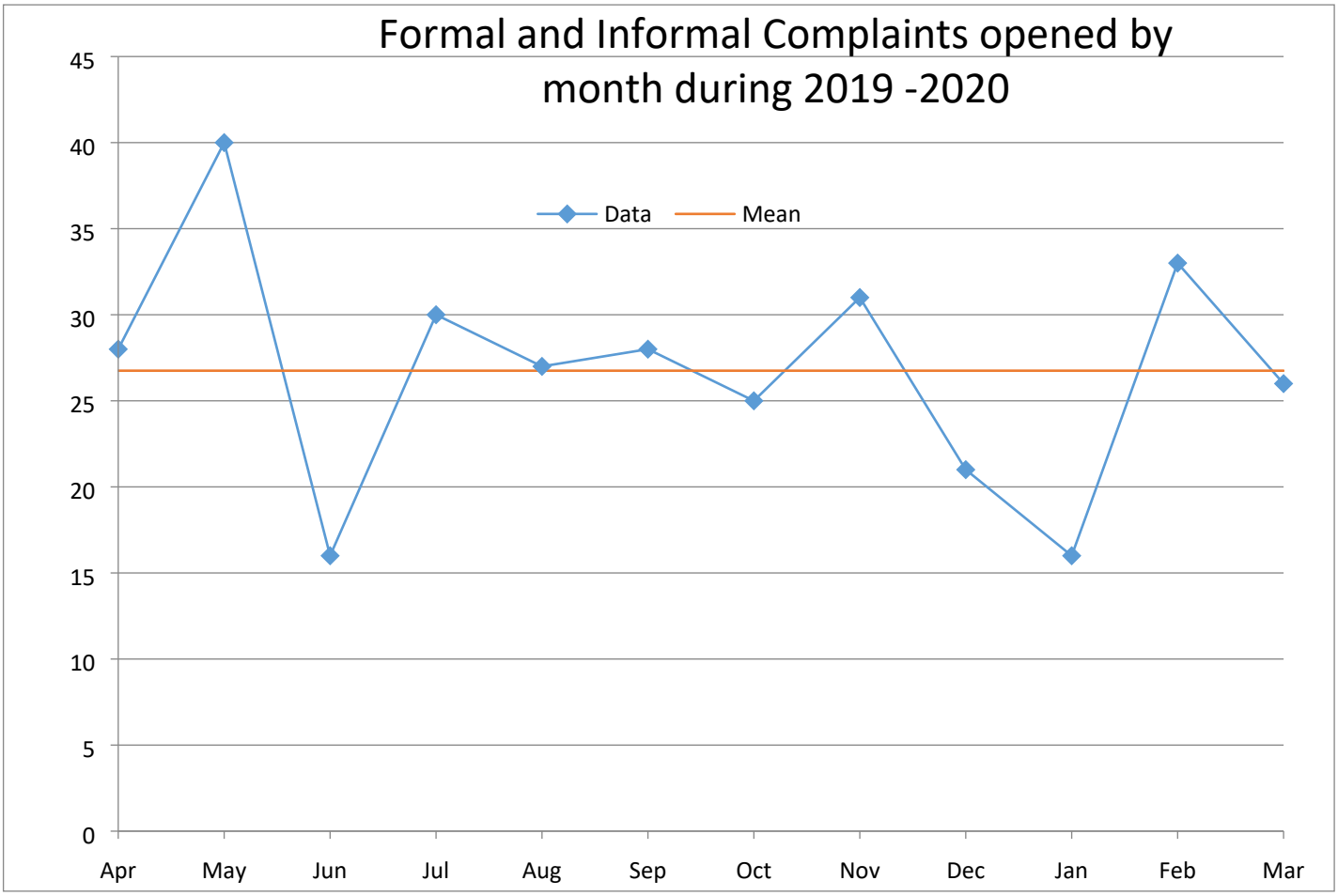
As at 30 April 2020, there were a total of 39 open serious incidents (comprising historical and current), of which 19 as at 30 April 2020 are currently being processed through to closure.

DETAILED BACKGROUND AND ASSESSMENT:

Management of Concerns and Complaints

Over the year 2019-2020 the health board received a total of 332 concerns inclusive of both formal and informal concerns. Specifically, during the Quarter 4 period, the total number of concerns received by the health board was 73 inclusive of formal and informal concerns.

The graph below (Figure 1) shows the breakdown by month of the number of formal and informal concerns received by the health board.



Source: Datix

The total number of formal concerns to date (n280) show an increase overall for 2019/20 compared to the previous year (n208), whereas informal concerns are showing a reduction from 127 reported for 2018/19 compared to 53 reported for 2019/20. Further analysis is required to understand the overall picture but it is possible the increase in formal concerns may reflect the changes early in 2019/20 whereby the timeframes for managing informal concerns reverted back to 2 working days as opposed to 5 working days, this change applied across NHS Wales. The increase of formal concerns in May

2019 can partly be attributed to the closure of the pain management clinic at Robert Jones and Agnes Hunt Orthopaedic Hospital. The health board received 12 complaints and queries from patients and Assembly Members and Councillors in relation to the health boards provisions for providing ongoing care.

With regards to setting/ location, the majority of the concerns relate to inpatient community hospital settings and General Practice (GP), with others related to community mental health, dental and commissioned services, Integrated Autism Service and the Child Adolescent Mental Health Service.

Concerns mainly related to the following staff groups:

- Medical and dental staff
- Scientific, therapeutic and technical staff
- Administration staff

With regards to subjects of the concerns, the following list is based on the primary subject of the concern raised:

- Access to services
- Appointments
- Attitude/ behaviour of staff

It is noted that during the Quarter 4 period there has been an increase in concerns raised in relation to access to GP Practices and staff attitude and patient's ability to access services across Powys Teaching Health Board.

Concerns Performance

Informal Concerns

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, have to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. Informal concerns are usually acknowledged at the time of taking the call or at the point of contact with the staff member.

During the 2019-2020 period the health board has achieved 88% overall and it is noted that the 100% target was achieved in in seven months during 2019-2020 in managing and acknowledging the informal concerns. Dedicated administration support is assisting improvements in this area. During April 2020 the health board achieved 100% in managing and acknowledging the informal concerns.

The health board set an internal target of 90% of informal concerns to be responded to within the new Welsh Risk Pool Services and Welsh Government target of 2 working days, as opposed to the previous 5 days.

The health board performance has been affected by the change in response timeframes, with only achieving a 73% target overall all during 2019-2020. Where an informal concern is not resolved in the timeframe, it transfers to a formal concern under the new Welsh Government guidance. Only 50% target was achieved in April 2020.

Formal Concerns

The focused work in closing formal concerns within the timescales has continued over Quarter 4 (Figure 2). During 2019-2020, the health board achieved 47% of formal concerns being closed within the 30-day target (Welsh Government target 75%), the percentage is based on the month in which the concern was opened.

Work has also taken place to clear concerns outside the 30-day target that were assessed as response within 30-working days. During Quarter 4, a total of 63 cases have been closed inclusive of those within the target of 30 working days. With a total of 277 formal concerns being closed during 2019-2020 which is shown in the graph below. It will be noted the increase in closed concerns at the start of Quarter 3 when the focused work commenced, however the closures have decreased during Quarter 4 which may be attributed to the Christmas period, the increased of staff using annual leave during the last quarter and the current Covid-19 situations, as it has been noted a decrease in staff's availability to respond timely to concerns raised.

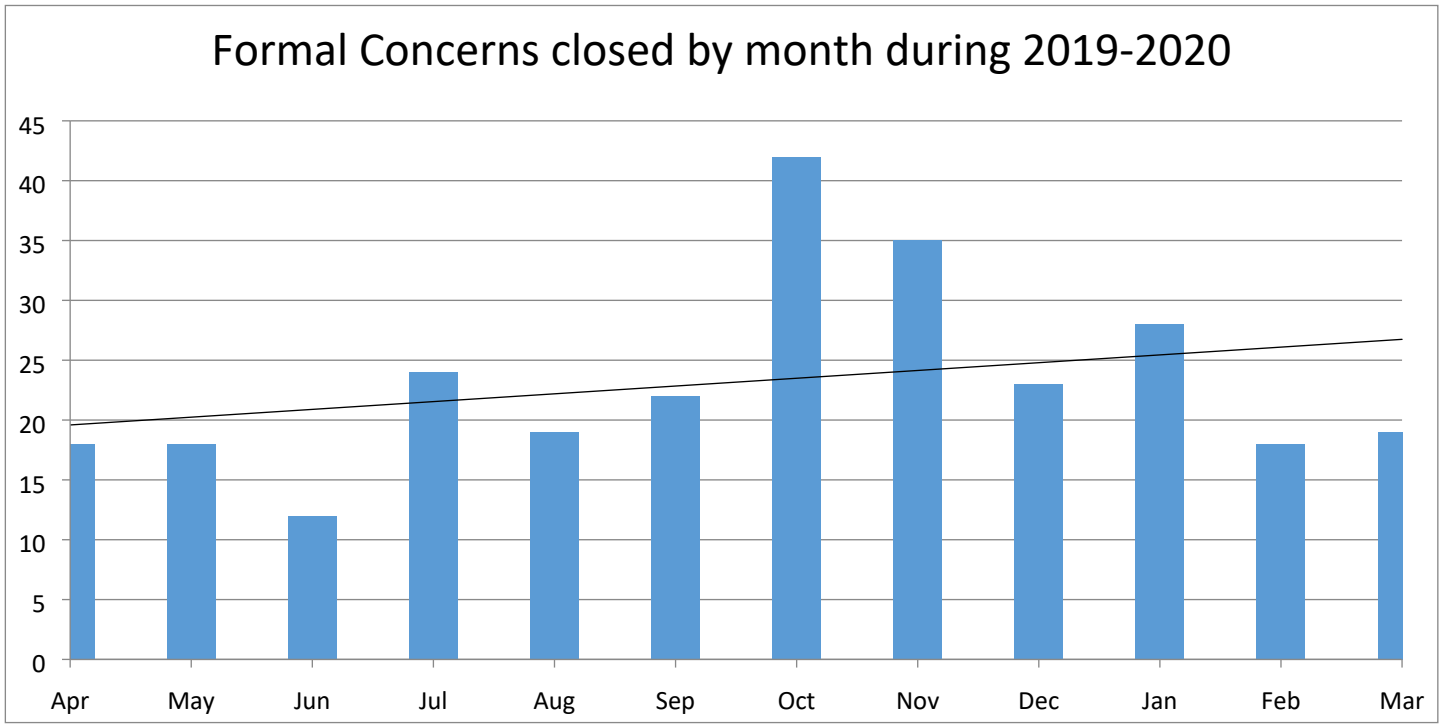


Figure 2 – number of closed concerns including those within target for 2019-2020

Source Datix

The focussed work continues to highlight to the team the importance of accurate assessment of concerns on receipt to ensure they are managed accordingly. Continued

focussed action remains in place to ensure effective management of concerns and includes:

- Weekly meetings to discuss current cases and timescales;
- Proactive action to ensure responses are drafted timely to meet response timeframes;
- Escalation of concerns where timely responses not available;
- Timely closing of concerns on the database to reflect true closure timeframes;
- A concerns response tracker has been developed to proactively ensure timeliness of responses;
- Allocation of cases between the team so there is ownership of the concern;
- Weekly reports to the Chief Executive Office until February 2020;
- Reporting to the new Director of Nursing from February 2020 with meetings being set up over the next couple of weeks to discuss the future plans on how to attain the Welsh Government Targets; and,
- Process mapping taking place within the team to stream line the processes.

Putting Things Right and Learning from Concerns

There is a key focus from Welsh Government and the Welsh Risk Pool to promote the importance of learning from the concerns that are received within the individual health boards.

To evidence that the health board has acted to learn from formal and informal concerns, reports on learning are presented to the quarterly Patient Experience Steering Group meetings as well as individual learning through wards and departments, newsletters, and 'You said, we did' boards.

From the Learning Reports being presented at the Patient Experience Steering Group, the Directorates have been reminded of the importance of the evidence of the shared learning and to provide minutes of meetings and memorandums for example to show that discussions have taken place with staff in relation to any learning identified and improvements made.

Through the Patient Experience Steering Group meetings, the Directorates are also reminded that as part of sharing learning and evidencing the impact of any learning there is a need to share any changes in processes and protocols as a result of concerns being raised by patients.

The review of lessons learnt from concerns for the 2019 – 2020 the following key themes have been identified throughout the year:

- Clear communication with patients
- Clear care plans in place for care for the patients and their families to understand the care that is needed for the patient
- Reminding staff of the importance of accurate record keeping
- Ensure appropriate discharge information is given
- To ensure all procedures are explained to patients before they undergo treatment
- Ensure patients are kept informed of changes in services

The health board will need to evidence how the sharing the learning has improved on the themes noted above and what is being done to promote good communication between staff, patients and families.

Serious Incidents

The task and finish group comprising Clinical Executive leads led by a Programme Director which was set up to progress activity and improve the way in which serious incidents are managed, from reporting through to investigation and closure is nearing completion of its work programme. The aim of the task & finish group was to progress work to close the historical open serious incidents that had exceeded the 60-working day timeframe. Out of a total of 36 historical cases, 21 have been closed by Welsh Government, a further 15 remain open of which 11 are currently going through the closure process and 4 cases outstanding for closure, all at varying stages, and with active work progressing to close them, it was the health board plan to close these by the end of March 2020 but this has not been achieved due to the pressures of Covid-19.

During the life of this group learning has been gathered to inform the way forward in managing serious incidents, the systems in use and processes applied. The key lessons and observations highlighted to date are:

- Improved serious incident oversight and coordination of serious incidents.
- Improved learning arrangements.
- Clarity on reporting structures, e.g. regular assurance reports to Quality Governance Group.
- Clarity within terms of reference for serious incident investigations, as properly written these provide the construct for the investigation and direct the investigating officer in what should be the most expedient route to support the whole process.
- Clarity of who each action belongs to and if an action is outside of the Board but has been highlighted to the necessary body, that we can close the serious incident as long as all of our actions are complete.
- Who is responsible for oversight of serious incidents within a service area? A single point of contact.
- Not waiting for a Coroner's inquest finding when conducting investigations.
- Closing down serious incidents when actions have yet to be completed. Should we be revisiting closed cases annually to confirm all scheduled actions completed?

Refreshed processes introduced alongside this work has supported active management of current open serious incidents. Positive feedback has been received with regards to staff engagement and actions taken in progressing investigations. This will be further strengthened when the draft serious incident policy is approved and a supporting investigating officer and staff education and awareness programme provided.

Performance and Assurance

NHS Organisations are required to provide Welsh Government with an assurance that a robust investigation has been completed and learning identified within 60 working days from the date the incident is notified.

Through the NHS Wales Delivery Framework and Reporting Guidance 2019-2020 (March 2019), the health board is required to provide a monthly position on the following:

1. Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales. (Internal target 90%)
2. Number of new never events.

The percentage assured within the agreed timescales has not to date achieved 100% in 2019/20, varying between 0%-33%, which often represents 1 case assured within the set timeframe. The revised processes are supporting improvements in this area, namely clinical executive oversight and coordination of serious incidents, improved tracking and follow up of serious incidents, strengthening of roles, responsibilities and accountability, local ownership and closure of serious incidents on the basis of robust internal investigations and action plans in place where Coroner reports and external investigation reports remain outstanding. Over the coming months as the revised processes embed it is envisaged timely investigations and actions will improve this position. The health board achieved 0% compliance during April 2020, this is attributed to the Covid-19 pandemic and there is proactive work ongoing to achieve the assurance timeframe where possible.

Over 2019-2020 the health board has reported 53 Serious Incidents, which is a slight decrease on the 55 Serious Incidents that the health board reported during 2018-2019. Welsh Government have closed 35 incidents reported during 2019-2020 this number is inclusive of the incidents closed as part of the historical cases noted above.

The position (historical and current) as at the end of the financial year is:

39 open serious incidents (includes 15 historical cases indicated above):

- 16 serious incidents have exceeded the 60-working day assurance timeframe, of which 10 serious incidents are processing through to closure via the Chief Executive and the 6 cases at varying stages, as indicated above; and,

- 23 serious incidents open and within the 60-working day assurance timeframe, with investigations progressing.

The position as at the end of April 2020 is:

39 open serious incidents (inclusive of the 15 historical cases indicated above)

- 20 serious incidents have exceeded the 60 – working day assurance timeframe of which 17 are currently processing through to closure via the Chief Executive and the 3 cases at varying stages of the process.
- 19 serious incidents open and within the 60 – working day assurance timeframe with investigations progressing.

At end March 2020 the Welsh Government have changed the reporting criteria in response to the Covid-19 pandemic, they introduced temporary reporting criteria with the view to ease the pressure on the health boards. As a result of this change there has been a decrease in serious incidents being reported to Welsh Government in line with the temporary changes. In addition, Welsh Government have advised the health board are not being monitored against the 60-working day assurance timeframe. Despite this temporary change the health board have advised staff to still report all incidents in line with the health boards policy and these are reviewed and investigations requested if necessary and where possible provided reports within the assurance target.

No *never events* have been reported during 2019-2020. There have been no never events reported during April 2020.

No Surprises

A total of 15 'No Surprises' reported for 2019-2020, all cases automatically closed within 3 working days unless this status is changed by Welsh Government who can upgrade the incident reported to a serious incident. This decision is communicated to the health board where Datix is updated to reflect this and the investigation process commenced.

Lessons for Sharing / Good Practice

Lessons highlighted for learning since the previous report show the importance of:

- The need to act on risk assessments where risks are clearly identified; and
- The importance of offering and encouraging patients to take regular fluids and making available a choice of fluids.

Learning from Events

At the last meeting the new reporting mechanisms for demonstrating learning from events (LfE) was shared. Having submitted completed LfE forms to Welsh Risk Pool Services for current redress cases in December 2019, evidence is now being requested to demonstrate learning has been put in place. If the evidence is not produced this will impact on reimbursement of monies from the Welsh Risk Pool Services to the health board for cases which the health board has paid out financial redress or compensation. Maternity services have been the first service within the health board who have been asked to provide evidence of learning that has taken place.

NEXT STEPS:

(1) To NOTE the actions underway to address areas of non-compliance and wher further improvement is needed.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.2

EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 4 JUNE 2020**
Subject:	**SHREWSBURY AND TELFORD HOSPTIALS NHS TRUST**
Approved and Presented by:	Alison Davies, Director of Nursing
Prepared by:	Assistant Director Commissioning Development
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

The purpose of this paper is to highlight to the Experience Quality and Safety Committee the findings of inspection reports recently published in relation to Shrewsbury and Telford Hospitals NHS Trust.

It also explains that is has not been possible to apply the PTHB Commissioning Assurance Framework during the COVID 19 period, but that the monitoring of domains is continuing where possible.

RECOMMENDATION(S):

It is recommended that the Experience Quality and Safety Committee DISCUSSES this report.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	×
	7. Put Digital First	×
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Shrewsbury and Telford NHS Trust (SaTH) is in special measures and three further inspection reports were issued by the Care Quality Commission (CQC) on the 8th April 2020:

SaTH 080420.pdf

RSH unnannounced Feb 20 080420.pdf

PRH 180220 080420.pdf

This report also explains that it has not been possible to apply the PTHB Commissioning Assurance Framework (CAF) during the COVID period, but the monitoring of domains is continuing where possible.

DETAILED BACKGROUND AND ASSESSMENT:

SaTH is the main provider of District General Hospital (DGH) care for North Powys residents. The Executive Committee and relevant Board Committees have been receiving up-dates through the CAF Escalation Report since SaTH was placed in special measures.

The CQC's original Inspection Report was published on the 29th November 2018 and is available on the CQC website. The emergency department, critical care

and maternity services were of particular concern. The trust had to take action to make all improvements necessary to give patients the standard of safe care they should be able to expect. The CQC told SaTH it must:

- Ensure sufficient and suitably qualified and trained staff are available to care for and protect people from the risk of harm.
- Keep all environments safe for use.
- Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe.
- Take account of the report from the Royal College of Obstetricians and Gynaecologists' review of current practice in maternity services and formulate action plans to improve the service.
- Review the processes around escalating women who are at high risk so that women who present at the midwifery led unit or day assessment unit receive a medical review without delay.
- Review its policy on reduced foetal movements so there is a clear and defined pathway for midwives and sonographers to follow.
- Ensure complaints are addressed within the timescale laid down by the trust's complaints policy.
- Doctors covering out of hours must have the capability and confidence to review patients at the end of life, including prescribing.
- All records must be safely and securely stored.
- The trust must improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis.
- Best practice must be followed when preparing, administering and storing medicines.

At that time the CQC found staff to be caring and dedicated and that there were areas of outstanding practice.

In April, 2019 the SaTH Board approved a Quality Improvement Plan in response to the Care Quality Commission's Inspection Report - addressing 79 "must dos" and 91 "should do" findings. The five main areas to be strengthened were:

- Services for women and children
- Scheduled Care
- Unscheduled Care
- Workforce
- Leadership

Further CQC inspections took place in April 2019 of the Emergency Departments at the Royal Shrewsbury Hospital and the Princess Royal Hospital. The findings, published on the 2nd August 2019, are available on the CQC website. The detail of the conditions imposed were reported to the Performance and Resources Committee on the 6th August 2019. The purpose of the conditions was to ensure that: all children who present to the emergency

department are assessed within 15 minutes of arrival; there is effective monitoring of the patient's pathway through the department from arrival; and that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional. Strengthened processes were put in place and a retrospective clinical audit carried out.

On the 6th December, 2019, the CQC published a quality report following an unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital on the 16th April, 2019. The full report is on the CQC website.

PTHB previously established a direct line of communication with the Care Quality Commission. Alongside the CQC and other commissioners PTHB is receiving copies of the weekly reports from SaTH to regulators and invitations to the Safety Oversight and Assurance Group.

The PTHB CEO also contacted NHS England and Improvement (NHSEI) about the independent review of maternity cases initiated by the Secretary of State in England to seek information about the terms of reference and progress of the review.

Up until the onset of the COVID period there had also been monthly Commissioning Quality Review Performance Meetings with SaTH and regular CEO level telephone conferences/meetings involving key Executives, the basis of which was a shared risk-based plan covering:

- Risk of significant harm to Emergency Department patients, including deteriorating patients with sepsis and children
- Risk of significant harm to maternal and perinatal patients
- Risk of significant harm to critically ill patients (including end of life care)
- Risk that the trust and services are not well-led
- Unsafe staffing
- Risk that patients will not be able to access services closer to home

The SaTH CEO received a further letter from the CQC due to the level of concern during its inspection in November, 2019. This was followed by a series of system wide Risk Summits led by NHSE/I, including the CQC, from December 2019, to consider further actions which could be taken focusing on the Emergency Department and consistent application of the Mental Health Act and Mental Capacity Act.

There has been significant change to the senior executive and professional leadership structure of the trust, including a new Chief Executive who started in February 2020.

Key findings of the new report: The most recent inspection reports have been provided in full. Overall the rating is as follows:

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

The safe, effective, responsive and well led key questions were all rated as inadequate. The caring key question went down to requires improvement. Royal Shrewsbury Hospital was rated requires improvement. The Princess Royal Hospital was rated as inadequate.

At present key English providers are working within regional system wide "Silver" and "Gold" arrangements in response to COVID-19. The difficulty in securing the next CEO level meeting was escalated to the PTHB "Gold" command and the CEO has been pursuing a request for a meeting.

The Assistant Director of Commissioning Development is participating in the daily system-wide meetings. The Assistant Director for Quality and Safety has been attending joint assurance meetings. The most recent key points from the assurance provided are as follows:

- Sepsis & deteriorating patient
  Screening on arrival - RSH 93%/ PRH 99%
  Sepsis 6 bundle compliance – PRH 93%/ RSH 67% (small sample impacting on %)
  Peer audits - 100% RSH/ 70% PRH (again small sample 10 patients)
  Observations recorded on arrival - PRH 96%/ RSH 97%
  Observations appropriately completed – PRH 95%/ RSH 88%
  Work progressed to change audit tool as some questions on version used.
  Internal professional standards. Monitoring of these will feature in improvement plan via CQC.
- Oversight of patient acuity & location
  Patients in the corridor – factors were flow and covid-19 issues. Zero tolerance to corridor care and importance of isolation. Not happened again.
- Paediatric triage
  90% RSH
  77% PRH
  Improvement

  All patients had triage time documented and this was an improvement on previous compliance
- Adult streaming (now called initial assessment)
  Spot audits to start
  Similar methods to paediatric approach
- Mental Health Risk Assessments
  PRH 91%
  RSH 95%
  New tool for mental health triage revised and task & finish group in place for sign off
- Staffing issues/risks
  26 band 5 staff delayed

13 in pipeline – in place end of June 2020 – some of these are newly qualified and will be in place August/ September
substantive posts – band 5 to 7 there are 71 currently and will be 110
quarantine timeframes impacting (2 weeks)
Band 6 no movement in staffing
Some work regards starters/ leavers – a dashboard in development to show ED position
Consultant/ Middle Grade remains fragile, some recruitment in process but some start dates delayed, e.g. impacted by house move.
Overseas middle grade – 7 due to arrive
Some resignations middle grade and junior due to starting GP training programme
No safeguarding issues
Registered children's nurses (agency nurses) not completing documentation, tend to be block bookings, same people, so picked up with agency

Never event linked to PTHB – report expected 8 June. (72-hour report received)

Commissioning Assurance Framework during the COVID Period

It is currently not possible to operate the PTHB CAF in the usual way. Whilst it has been suspended monitoring within domains is continuing where possible.

Access: There are virtually no routine services in place at present and performance management arrangements for scheduled and unscheduled care have been suspended by central governments. PTHB is attempting to monitor key issues in relation to essential services such as Cancer breaches. In line with other health boards it has recently started to report to Welsh Government on access to essential services.

Finance and Activity: The usual financial arrangements are not in place and block funding arrangements are being used (and may be extended until at least October in England). Thus, it is not possible to monitor financial performance and activity against the forecast 2020/21 levels. (Emergency activity has reduced by up to 50% and routine activity has been suspended.)

The remainder of the year remains unpredictable due the continuing presence of COVID; reduced DGH capacity to prevent hospital transmission; the backlog of patients who have not been seen; the rate at which services can be restored and limiting factors such as staffing, PPE and anaesthetic medicines; the onset of winter and flu; and the EU departure.

Quality and Safety (& Patient Experience): Where possible quality and safety measures are continuing to be monitored. However, this is not straight

forward as, for example, concerns related to the suspension of routine services are linked to a Government direction.

Governance and Strategic Change: A "DGH Log" is being kept to try and record the multiple and complex pathway changes which are taking place during this period.

Maternity Thematic View: This is continuing (but it has not been possible to take forward the planned work with CTMUHB and ABUHB at this stage).

Commissioning Quality Performance and Review Meetings (CQPRMs): are not taking place at present. The main English providers for PTHB are working within regional system wide "Silver" and "Gold" arrangements.

For the reasons above the Corporate Risk score for commissioned services have been increased to 20. However, the PTHB Phase 2 COVID Response Plan includes developing a plan to reinstate processes such as the CAF where possible.

Conclusion

Three further concerning reports have been published by the CQC in relation to SaTH, which is already in special measures. The CEO is seeking a meeting with the new CEO there including key executives.

It has not been possible to continue to apply the PTHB CAF during the COVID period but the monitoring of key domains is continuing where possible. The corporate risk score for commissioned services has been increased to 20. During Phase 2 plans will be developed to try and restore key commissioning processes where possible.

NEXT STEPS:

The relevant board committees will be updated.

Shrewsbury and Telford Hospital NHS Trust

Inspection report

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

Date of inspection visit: 12 November 2019 to 10 January 2020
Date of publication: 08/04/2020

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

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

Summary of findings

Background to the trust

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

The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019.

Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services.

The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Hospital sites at the trust

A list of the trust's acute hospitals is below. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

- Princess Royal Hospital - Apley Castle, Telford, Shropshire TF1 6TF
- Royal Shrewsbury Hospital - Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XQ

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Inadequate 

What this trust does

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We carried out a core service inspection and well led review. We visited both hospitals and inspected the following core services between 12 to 20 November 2019:

Princess Royal Hospital (PRH):

- Urgent and emergency care.
- Medical care.
- Surgery.
- Maternity.
- Children and young people.
- End of life care.
- Outpatients.

Royal Shrewsbury Hospital (RSH):

- Urgent and emergency care.
- Medical care.
- Surgery.
- End of life care.
- Outpatients.

We carried out a well led review on 8 to 10 January 2020. To assess if the organisation was well-led, we interviewed the members of the board, the executive team and held a focus group with non-executive directors and a range of staff across the hospital. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders. The well-led review team comprised of a head of hospital inspection, inspection manager, inspector, pharmacy specialist, an executive reviewer from another NHS trust, two special clinical advisors with significant experience of governance and NHS trust boards and NHS England/improvement.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Summary of findings

Our rating of the trust stayed the same. We rated it as inadequate because:

- The safe, effective, responsive and well led key questions were all rated as inadequate.
- The caring key question went down to requires improvement.
- Royal Shrewsbury Hospital was rated requires improvement.
- The Princess Royal Hospital was rated as inadequate.

Are services safe?

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

- Princess Royal Hospital (PRH) was rated as inadequate for safety overall.
- Core services urgent and emergency care and medical care at PRH were rated as inadequate for safety.
- Outpatients at PRH was rated as good for safety.
- Surgery, maternity, services for children and young people and end of life care at PRH were all rated as requires improvement for safety.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for safety overall.
- Urgent and emergency care at RSH was rated as inadequate for safety.
- All other core services were rated as requires improvement.

Are services effective?

Our rating of effective went down. We rated it as inadequate because:

- Princess Royal Hospital (PRH) was rated as inadequate for effective overall.
- Core services urgent and emergency care and medical care at PRH were rated as inadequate for effective.
- Maternity at PRH was rated as good for effective.
- We do not rate outpatients for effectiveness.
- All other core services were rated as requires improvement for effective at PRH.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for effective.
- Urgent and emergency care at RSH was rated as inadequate for effective.
- We do not rate outpatients for effectiveness.
- All other core services at RSH were rated as requires improvement.

Are services caring?

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

- Both hospitals were rated as requires improvement for caring.
- Surgery, maternity and outpatients at Princess Royal Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.
- End of life care and outpatients at Royal Shrewsbury Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.

Summary of findings

Are services responsive?

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

- Princess Royal Hospital (PRH) was rated as inadequate for responsive overall.
- Core services urgent and emergency care and children and young people at PRH were rated as inadequate for responsive.
- Outpatients at PRH was rated as good for responsive.
- The other core services inspected at PRH were rated as requires improvement.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for responsive.
- Urgent and emergency care at RSH was rated as inadequate for responsive.
- All other core services inspected at RSH were rated as requires improvement.

Are services well-led?

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

- Royal Shrewsbury Hospital was rated as requires improvement for well led.
- Princess Royal Hospital was rated as inadequate for well led overall.
- Overall, the trust was rated as inadequate for well led.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in some areas, see below for more information.

Areas for improvement

We found areas for improvement including 92 breaches of legal requirements that the trust must put right. We found 75 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued nine requirement notices to the trust. We also took urgent action and issued eight new conditions of registration and varied two existing conditions of registration as well as issuing a section 29 A warning notice.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

We found examples of outstanding practice in:

In Outpatients at PRH:

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.
- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

In Surgery at RSH:

- We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust must take to improve:

At trust Well led level:

- Ensure there are effective governance systems and process in place to effectively assess, monitor and improve the quality and safety of services. Regulation 17 (1): Good governance.
- Ensure there are effective systems and process to assess monitor and mitigate risks. Regulation 17(2): Good governance.
- Ensure there is consistent use and completion of the incident investigation form for serious incidents, that learning is clearly identified, actions developed, and impact reviewed. Regulation 17(1): Good governance.
- Ensure the backlog of incidents awaiting review is reduced. Regulation 17(1): Good governance.
- Ensure that robust processes are in place to confirm all directors are fit and proper for the role. Regulation 5: Fit and proper persons – directors

In Urgent and emergency care at PRH:

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.

Summary of findings

- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.
- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.
- Ensure they review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. Regulation 17 (1) (2) (a): Good governance.
- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.
- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.
- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.
- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

In Medical care at PRH:

The service MUST take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.
- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.
- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.
- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.
- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.
- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.
- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.
- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.

Summary of findings

- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

In Maternity at PRH:

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.
- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.
- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.
- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.
- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.
- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

In Children and Young People care at PRH:

The service MUST take action to:

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.
- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.
- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

In End of life care at PRH:

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.

Summary of findings

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

In Urgent and emergency care at RSH:

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.
- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.
- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.
- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.

Summary of findings

- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.
- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.
- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.
- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.
- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.
- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.
- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.
- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.
- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

In Medical care at RSH:

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.
- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.
- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.

Summary of findings

- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.
- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.
- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

In Surgery at RSH:

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.
- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.
- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.
- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.
- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.
- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

In End of life care at RSH:

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.

Summary of findings

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

In Outpatients at RSH:

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.
- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

Actions the trust should take to improve:

At trust well led level:

The trust SHOULD take action to:

- Progress the plans to review the vision, strategy and values to promote high quality care.
- Consider how leaders can be more visible to staff, with recognition from staff of this visibility.
- Develop and support a culture in which staff feel supported, respected and valued.
- Finalise and implement the digital strategy so that information technology systems are used effectively to accurately monitor and improve the quality of care.

In Urgent and emergency care at PRH:

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.
- Review departmental risk registers to ensure actions are updated in a timely manner.
- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.
- The service should obtain an observation policy and a robust restraint policy in place.

In Medical care at PRH:

The service SHOULD take action to

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.
- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.
- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

Summary of findings

In Surgery at PRH:

The service SHOULD take action to:

- Summary of findings 12 Shrewsbury and Telford Hospital NHS Trust Inspection report April 2020
- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.
- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.
- Continue to try and improve flow through theatre and reduce the number of cancelled operations.
- Continue to try and improve the admitted pathway referral to treatment times.
- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.
- Make improvements in the National Hip Fracture Database audits outcomes.

In Maternity care at PRH:

The service SHOULD take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.
- The trust should ensure all staff complete accurate documentation around CTG monitoring.
- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.
- The trust should ensure that all midwives have an annual appraisal.

In Children and Young People care at PRH:

The service SHOULD take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.
- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

In End of life care at PRH:

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death. The service should undertake audits for pain or symptom control for end of life care patients.

In Outpatients at PRH:

Summary of findings

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.
- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.
- Monitor that medical staff complete patient records in a clear and legible way.
- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.
- Consider ways to improve staff engagement with senior leaders and the executive team.
- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.

In Urgent and emergency care at RSH:

The trust SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.
- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.
- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.
- The service should continue to work with commissioners to improve ambulance handover times.
- The service should continue to embed local initiatives aimed to improve sepsis care.
- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.
- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.
- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.
- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.
- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.
- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.
- The service should explore how to effectively display patient safety information within the ED.
- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).
- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.
- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.

Summary of findings

- The service should continue with the implementation of a suitable competency tool for staff working.

In Medical care at RSH:

The service SHOULD take action to

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.
- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

In Surgery at RSH:

The service SHOULD take action to:

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.
- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.
- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.
- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.
- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.
- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.
- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.
- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.
- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.
- The service should consider reviewing management staffing out of hours to support the provision of seven day working.
- The service should review the process for providing agency staff with immediate access to electronic records and systems.

In End of life care at RSH:

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.

Summary of findings

- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

In Outpatients at RSH:

The service SHOULD take action to:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.
- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.
- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.
- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.
- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well led at the trust as inadequate. This was the same as the previous inspection. We rated it as inadequate because:

- There was a lack of stability in the executive team with several interim members, although to increase stability these individuals had agreed to stay in post until substantive post holders were in place. The board had some knowledge of the current challenges and were acting to address these however this had not made the sustained improvements required to deliver high quality care and in some areas the quality of care had deteriorated. Not all leaders at all levels had the capacity and capability to lead effectively.
- The trust's strategy, vision and values were developed in 2016 and had not delivered on all the objectives set. Progress against delivery of the strategy and plans was not consistently or effectively monitored or reviewed and there was little evidence of progress. Leaders at all levels were not always held to account for the delivery of the strategy. Staff informed us they did not always observe or experience members of the executive team displaying the trust values in their behaviours.
- There was an improving understanding of the importance of culture, however, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated.

Summary of findings

Staff reported the culture was top-down and directive. Staff told us about high levels of bullying, harassment and discrimination, and the organisation was not taking adequate action to reduce this. When staff raised concerns, they were not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. There was improving attention to staff development and improving appraisal rates.

- The arrangements for governance and performance management were not always fully clear and did not always operate effectively. Staff were not always clear about their roles, what they were accountable for, and to whom. Governance systems were ineffective to ensure quality services were provided.
- Although the trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected these were not working effectively.
- The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders recognised the quality of data was poor however they were relaying on and taking assurance from this data. Information was used mainly for assurance and rarely for improvement. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not always robust.
- Staff felt they were not listened to and were sometimes fearful to raise concerns or issues, these were issues at the last inspection.
- Improvements were not always sustained. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance. Systems lacked maturity and senior leaders recognised this.

However,

- Required data or notifications were submitted to external organisations.
- The trust engaged with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➔➔ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ➔➔ Apr 2020	Inadequate ➔➔ Apr 2020

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Shrewsbury Hospital	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ↑ Apr 2020
Princess Royal Hospital	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Overall trust	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020

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

Ratings for Royal Shrewsbury Hospital

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

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

Ratings for Princess Royal Hospital.

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

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

The Princess Royal Hospital

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Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Princess Royal Hospital has 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Summary of services at The Princess Royal Hospital

Inadequate 

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

- The safe key question remained as inadequate.
- Effective key question went down to inadequate.
- Caring key question went down to requires improvement.
- Responsive went down to inadequate.
- Well led key question remained as inadequate.

Urgent and emergency services

Inadequate 

Key facts and figures

Details of emergency departments and other urgent and emergency care services at this trust:

- Royal Shrewsbury Hospital emergency department.
- Princess Royal Hospital emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a major's unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department. Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics. The internal layout of the Emergency Department (ED) comprises of a main waiting area. Within this area there were two hatches; one where patients book in and see a streaming nurse (for minor injuries); the other is used for all 'walk in' patients to book in with reception staff. A triage room leads off the main waiting room. Within the treatment areas there were four 'minors' cubicles (for patients with minor injuries and illness), eight 'majors' cubicles (for patients with major illness or injury) and a paediatric treatment room. In addition, there were two 'pit stop' cubicles where rapid assessments took place following triage, and two areas for 'fit to sit' patients. One of these cubicles had chairs where patients who were well enough to sit and wait further assessment. The other 'fit to sit' cubicle was a bed where patients could be examined individually if necessary. There was also a separate treatment room which was used for patients with communicable infections. If this room was in use, infectious patients were transferred to the ED theatre. The ED theatre was otherwise used for procedures such as minor suturing. There was also a plaster room to use when the fracture clinic facilities were not available. A further 'Swan' room was also used to locate patients who were at the end of life in the department.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- Managers did not make sure that everyone completed their mandatory training. Not all staff had completed their safeguarding training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.
- The design and use of facilities for patients were not designed to keep people safe. Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor. The service had variable rates around vacancy and bank usage for their staff. The service sometimes had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff sometimes kept detailed records of patients' care and treatment. Records were sometimes clear, up-to-date. The service sometimes used systems and processes to safely prescribe, administer, record and store medicines.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers sometimes ensured that staff followed guidance and were kept up to date on evidence-based practice. Patient outcomes were worse than national averages. The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.

Urgent and emergency services

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Patients were not always respected of their privacy and dignity or considered their individual needs. Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.
- The service sometimes planned and provided care in a way that met the needs of local people and the communities served. The trust sometimes worked with others in the wider system or local organisations to plan care. The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services. Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- Leaders did not always understand or manage the priorities and issues the service faced. The trust did not always use a systematic approach to continually improve the quality of its services. Governance was not effective to monitor and manage risks on a regular basis to improve. This placed patients at significant risk of harm. The department did not always have effective systems for identifying risks. The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.
- The department had not learnt from some of the findings from the last inspection.

Is the service safe?

Inadequate  

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

- Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor.
- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Managers did not make sure that everyone completed their mandatory training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.
- Not all staff had completed their safeguarding training.
- The design and use of facilities for patients were not designed to keep people safe.
- Managers investigating incidents did not always share lessons learned with the whole team or the wider service.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Urgent and emergency services

- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- Managers reviewed staffing levels and skill mix and gave locum staff a full induction.
- The service had nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were stored securely and easily available to all staff providing care.
- The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always ensure that staff followed guidance and were kept up to date on evidence-based practice.
- Patient outcomes were worse than national averages.
- The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to improve outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement  

Urgent and emergency services

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

- Patients were not always respected of their privacy and dignity or considered of their individual needs.
- Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.

However,

- Staff treated patients with compassion and kindness.
- Staff understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Inadequate 

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

- Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- The service did not always plan and provide care in a way that met the needs of local people and the communities served. The trust did not always work with others in the wider system or local organisations to plan care.
- The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services.

However,

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

Is the service well-led?

Inadequate 

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

- Leaders did not understand or manage the priorities and issues the service faced.
- The trust did not use a systematic approach to continually improve the quality of its services.
- Governance was not effective to monitor and manage risks on a regular basis to improve. This placed patients at significant risk of harm.
- The service did not have effective systems for identifying risks.

- The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.
- The service had not learned from some of the findings from the last inspection

However,

- Leaders had the skills and abilities to run the service.
- Local leadership were visible and approachable in the service for patients and staff. Local leadership supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued by local leaders. They were focused on the needs of patients receiving care. The department provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns.
- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff engaged with patients and staff.
- All staff were committed to continually learning.

Areas for improvement

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.
- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.
- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.
- Ensure they review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. Regulation 17 (1) (2) (a): Good governance.
- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.
- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.
- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.
- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.
- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.
- Review departmental risk registers to ensure actions are updated in a timely manner.
- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.
- The service should obtain an observation policy and a robust restraint policy in place.

Medical care (including older people's care)

Inadequate ↓

Key facts and figures

The trust's medical care service provides care and treatment for specialties including cardiology, gastroenterology, neurology, oncology, respiratory medicine and stroke medicine.

(Source: Routine Provider Information Request AC1 - Acute context)

The medical care service at Princess Royal Hospital provides care and treatment for specialties including cardiology, gastroenterology, neurology, respiratory medicine and stroke medicine.

The hospital has 211 medical inpatient beds located across 11 wards and units:

The trust had 77,043 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 30,006 (38.9%), 571 (0.7%) were elective, and the remaining 46,466 (60.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,878
- Gastroenterology: 20,301
- Clinical oncology: 12,649

(Source: Hospital Episode Statistics)

Our inspection of this service was unannounced (the trust did not know we were coming). During our inspection we visited all areas where medical services were delivered from. We spoke with staff of all levels including health care assistants, nurses, ward manager, matrons, junior doctors, registrars and consultants. We spoke with patients and their families about the care and treatment they had received at the trust. During our inspection we also reviewed patient documentation and requested further evidence from the trust.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.
- We had concerns about the administration of rapid tranquilization.
- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff did not always report incidents.

Medical care (including older people's care)

- Distress in the open environment was not always handled discreetly.
- The service did not always consider of patients' individual needs and preferences.
- Not all staff felt respected, supported and valued.
- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

However:

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The service provided mandatory training in key skills to all staff. However, not everyone had completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received training on how to recognise and report abuse.
- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Not all equipment was well maintained and ready for use or used safely.
- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.
- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.
- We had concerns about the administration of rapid tranquilisation.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

- The service did not make sure all staff were competent for their roles.
- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieved good outcomes for patients.
- Not all key services were available seven days a week to support timely patient care.

However:

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Is the service caring?

Requires improvement

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

- Staff did not always treat patients with compassion and kindness or respect their privacy and dignity.
- Distress in the open environment was not always handled discreetly.

However:

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

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not always consider of patients' individual needs and preferences.

However:

- The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- Most people could access the service when they needed it and received the right care promptly.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.
- It was easy for people to give feedback and raise concerns about care received.

Medical care (including older people's care)

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Not all issues and priorities to the service were understood.
- Not all staff felt respected, supported and valued. Staff told us the culture was not always supportive of raising concerns without fear.
- Although there were governance systems in place these were not operating effectively to improve the quality of services.
- Although there were systems in place to mitigate risks, these were not working effectively. Not all risks to the service had been identified and escalated with actions to reduce their impact, risk identified at previous inspections had not been resolved.
- All staff were committed to continually learning and improving services however not all actions taken had improved patient care.

However:

- Leaders had the integrity, skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services

Areas for improvement

The service Must take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.
- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.
- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.
- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.
- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.
- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.
- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.

Medical care (including older people's care)

- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.
- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

The service Should take action to:

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.
- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.
- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

Surgery

Requires improvement ➔➔

Key facts and figures

Surgery services provided by Shrewsbury and Telford NHS trust are located on two hospital sites which provide both elective and emergency surgery to the population of Shrewsbury, Telford, Wrekin and the wider areas. Royal Shrewsbury Hospital, Shrewsbury and The Princess Royal Hospital, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the scheduled care group across both hospitals with the same clinical directors. For this reason, there may be some duplication contained within the two evidence appendices.

The surgery core service at Princess Royal Hospital includes breast surgery, ENT, maxillofacial surgery and planned and emergency orthopaedics. In addition, the hospital accepts all head and neck emergency patients referred by GPs and admitted from the emergency departments at both the trust's acute sites.

Princess Royal Hospital has eight operating theatres (excluding the two maternity operating theatres which are not relevant to this core service) and 106 surgical inpatient beds and day case trollies located across four wards and units.

The trust had 31,414 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 12,930 (41.2%), 3329 (10.6%) were elective, and the remaining 15,155 (48.2%) were day case.

We inspected the service from the 18 to 20 of December 2019. As part of the inspection we visited the following areas:

- Day Surgery Unit
- Ward 4 (trauma and orthopaedics)
- Ward 8 (trauma and orthopaedics)
- Ward 17 (head and neck/elective orthopaedics)
- Day surgery theatres
- Main theatres
- Theatre recovery

During the inspection we spoke with 14 patients, 51 staff and reviewed 12 patient records and 17 prescription charts. We reviewed policies, performance information and data about the surgical service.

The service was last inspected in 2018. At the last inspection it was rated as requires improvement overall and for safe, effective, responsive and well led. Caring was rated as good.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.
- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.

Surgery

- There were some wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)
- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.
- From August 2018 to July 2019 the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.
- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.

However,

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.
- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.
- There were some wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)
- Prescribers did not always write separate prescriptions for medicines (paracetamol) that could be given by either the oral or intravenous route. Nurses sometimes failed to record the actual dose administered for pain relief medicines when they were prescribed as a variable dose.

Surgery

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service mainly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well**.**
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- Although there were examples of using the findings to make improvements this was not consistent in all audits and in the National Hip Fracture Database showed a deterioration.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Surgery

- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Good ➔➔

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.
- From August 2018 to July 2019, the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.

However,

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Surgery

Is the service well-led?

Requires improvement ➔➔

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

- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.
- Inaccurate marking of surgical sites and inaccurate recording on consent forms and theatre lists was not on the risk register. Although the head of quality and safety was aware of the issue, we were not assured that this risk had senior management oversight and regular review.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, and the public to plan and manage services.
- All staff were committed to continually learning and improving services.

Areas for improvement

The service should take action to:

- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.
- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.
- Continue to try and improve flow through theatre and reduce the number of cancelled operations.
- Continue to try and improve the admitted pathway referral to treatment times.
- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.
- Make improvements in the National Hip Fracture Database audits outcomes.

Maternity

Requires improvement ➔➔

Key facts and figures

The trust has 70 maternity beds. Of these beds 53 are located within the consultant-led maternity unit at Princess Royal Hospital:

Ward/unit	Specialty or description	Inpatient beds
Ward 21	**Postnatal**	**23**
Ward 22	**Antenatal**	**13 inpatient and 4 triage beds**
Ward 24	**Delivery suite**	**13 *en-suite* delivery rooms**

The delivery suite has a pool room and includes the two maternity theatres and recovery area.

The Wrekin midwife-led unit is situated in the grounds of the Princess Royal Hospital. The unit has 17 beds. These include four birthing rooms, one with a birthing pool. Postnatal care is provided in four bed bays. Many women who have had a baby in the consultant unit transfer to the Wrekin Unit for postnatal care.

We spoke with 46 members of staff including midwives, doctors, maternity support workers, sonographers, ward clerks and housekeepers. We also spoke with seven women and four of their relatives. We observed interactions between women and staff, considered the environment and looked at 36 women's care records and six prescription records. We also reviewed other documentation from stakeholders and nationally published data for the trust.

The midwife-led unit at Royal Shrewsbury Hospital is currently closed to inpatients, because of non-compliance with building regulations. The midwife-led units at Bridgnorth, Ludlow and Oswestry are currently closed due to staffing. This is subject to the ongoing review of the Midwifery Led maternity services, commissioned by the Shropshire and Telford CCGs, and the awaited public consultation.

The trust also provides antenatal and postnatal care from community bases at Whitchurch and Market Drayton.

The trust's maternity service provides antenatal, postnatal and intrapartum obstetric and maternity care that includes scanning, early pregnancy assessment and triage.

The trust noted that midwifery-led care in the area is currently being reviewed by Shropshire, Telford & Wrekin Clinical Commissioning Group in line with the National Maternity Review (Better Births) 2016.

(Source: Trust Provider Information Request – Sites tab and Acute context; trust website)

From January 2018 to December 2018 there were 4,350 deliveries at the Trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

We rated effective, caring and responsive as good. Safe and well led were rated as requires improvement.

Maternity

- Staff did not always complete training in key skills. Staff did not protect patients from abuse in line with trust policy staff were not asking about domestic abuse in line with trust policy. Safety incidents were not always graded and reported incidents correctly according to harm. Staff did not always ensure medical staff assessed risks to patients. The service did not always ensure women received one to one care in labour. Staff did not always complete all risk assessments.
- Some leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. Leaders and teams did not always use systems to manage performance effectively. Not all performance data was formatted in line with national guidance. Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

However,

- They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers mostly monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement ↑

Our rating of safe improved. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff, however the trust target for attendance at training was not met by the service. Midwifery staff were not compliant with all mandatory update requirements.
- Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. However, not all staff identified and quickly acted upon women and their babies at risk of deterioration.
- The service made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development. However, managers did not appraise all staff's work performance.
- Eligibility of medical staff for safeguarding children level 3 training was low.

However:

Maternity

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean, however we found minute traces of body fluids were evident on one chair and a bed**.**
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service, however incidents were not always graded correctly according to the level of harm. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Is the service effective?

Good ↑

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.
- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave women practical support and advice to lead healthier lives.

Maternity

- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.
- However, managers did not appraise all staff's work performance.

However,

- The service generally made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development.

Is the service caring?

Good ➔➔

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

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment. Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Good ➔

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.
- Women could usually access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards. However, discharge from the triage unit was not always in line women's care plans.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Maternity

Is the service well-led?

Requires improvement ➔➔

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

- Some leaders did not have the skills and abilities to effectively lead the service and did not always operate effective governance processes throughout the service and with partner organisations.
- Leaders did not have full oversight of the risks that were identified during the inspection with regard to poor risk assessments, one to one care, domestic abuse, carbon monoxide screening.
- Leaders and teams did not always identify relevant risks within the service and therefore did not identify actions to reduce their impact.

However,

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.
- The maternity service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards. Staff understood their responsibilities regarding accessing and storing confidential information
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Areas for improvement

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.
- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.
- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.
- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.

Maternity

- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.
- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.
- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

The service should take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.
- The trust should ensure all staff complete accurate documentation around CTG monitoring.
- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.
- The trust should ensure that all midwives have an annual appraisal.

Services for children and young people

Requires improvement

Key facts and figures

The trust has 36 paediatric inpatient beds located on Ward 19 at Princess Royal Hospital. Children up to the age of 16 years can be admitted to the children's ward. Once a patient reaches their sixteenth birthday they will be admitted to an adult ward.

The hospital also has a children's assessment unit consisting of eight assessment beds where children are assessed to determine if they require admission to the children's ward or treatment prior to discharge home. The unit is open 24 hours seven days a week.

The hospital's neonatal unit (Ward 23) is commissioned to provide 22 cots, however when in periods when demand is high the trust can increase this to 23 cots.

There is a medical day unit at Royal Shrewsbury Hospital for children with long term conditions requiring outpatient assessment and diagnostics. This service is open from 9am to 5pm Monday to Friday.

The trust had 9,068 spells in its services for children and young people from March 2018 to February 2019.

Emergency spells accounted for 91% (8,275), 7% (620) were day case and the remaining 2% (173) were elective

During our inspection we spoke with seven patients and their families, we checked 10 pieces of equipment, seven sets of patient records and seven prescription charts.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.
- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.
- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.
- The design, maintenance and use of facilities, premises and equipment kept people safe, however some environments did not follow national guidance. Children and young people were not separated from adults in the day surgery and the main theatre recovery areas.
- The service did not always make sure staff were competent for their roles. Staff were not trained to care for children and young people with mental health needs, learning disabilities or autism.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

Services for children and young people

- The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care. The service did not have a transition lead nor a transition policy to support children and young people moving into adult services. There were very limited facilities to support the needs of children and young people with additional needs.
- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.

However,

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.
- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.
- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.

However,

- The design of the environment, maintenance and use of facilities, premises and equipment kept people safe.
- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.

Services for children and young people

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

However,

- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for children, young people and their families' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.

Services for children and young people

- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions.

Is the service caring?

Requires improvement ↓

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

- Patients with additional needs including mental health, learning disabilities and autism were not always treated equally. For example, we saw and were told patients with mental ill health were not permitted to mix.

However,

- Staff provided emotional support to children, young people and their families to minimise their distress.
- Staff supported and involved most children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.
- Staff treated most children, young people and their families with compassion and kindness.

Is the service responsive?

Inadequate ↓↓

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

- The service did not always plan and provide care in a way that met the needs of local people and the communities served.
- Staff did not always make reasonable adjustments to help children, young people and their families access services or coordinate care with other services and providers. Young people over 16 were not generally offered access to children and young people's wards.
- The service did not have training and systems in place to respond to a gap in CAMHS support at weekends and evenings.
- The service did not have a transition lead nor a transition policy to support children and young people moving into adult services.
- There were very limited facilities to support the needs of children and young people with additional needs.

However,

- The service was mostly inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

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

Is the service well-led?

Requires improvement ↓

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

- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.
- The service did not always promote equality and diversity in daily work and provide opportunities for career development. The service leads had not sought further development for staff working with patient with additional needs such as mental health, autism or learning disabilities, therefore did not always promote equality and diversity.
- Staff were unaware of the service vision and strategy and were not involved in the creation of them.
- Leaders operated governance processes throughout the service and with partner organisations, however they were not all effective as they were not yet embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Systems that managed performance were effective. Leaders and teams had identified and escalated most relevant risks and issues and identified actions to reduce their impact. Leaders and teams had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated, and all patient records were stored securely.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

The service Must take action to:

Services for children and young people

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.
- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.
- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

The service should take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.
- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

End of life care

Requires improvement ➔➔

Key facts and figures

The trust provides end of life care at two of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, three ward managers, five ward sisters, four nurses, two healthcare assistants, the head of pathology, the mortuary manager, the bereavement manager, the chaplain, two administrators, three porters, three patients and four family members. We also reviewed 11 care records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.
- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff used infection control measures when visiting patients on wards and transporting patients after death.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- Records were stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

End of life care

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

Is the service safe?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service effective?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not audit pain and symptom control, or time taken for fast track audits.
- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However:

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

End of life care

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Requires improvement 

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

- We found in the children's viewing room the bedding for the children's cot and the teddy bear placed in the viewing cot were visibly dirty. There were also two bassinets of different sizes for the viewing of babies. Each bassinet had a silk lining, both bassinettes' linings were dirty. One of the bassinet's silk lining had what appeared to be a large dried liquid stain. We asked the mortuary staff member when the bedding was last cleaned, we were advised that it was not known if the bedding had ever been cleaned. We escalated this to the trust, who immediately replaced the bedding in the viewing cot and bassinets
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

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

- The service did not audit waiting times from referral to achievement of preferred place of care and death.

However;

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint

End of life care

Is the service well-led?

Requires improvement 

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

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.
- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.
- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Areas for improvement

The service Must take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

The service should take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.

End of life care

- The service should ensure it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Good

Key facts and figures

Outpatient services at Shrewsbury and Telford NHS Trust are provided mainly at The Princess Royal hospital and the Royal Shrewsbury hospital sites, with a small number of services within the community. Across the trust, outpatients services is managed by scheduled and unscheduled care groups and various specialties. The Scheduled Care Group manages a large proportion of the outpatient activity and associated nursing support across both main trust sites and also at the satellite sites. The Scheduled Care Group manages all the musculoskeletal services which provides outpatients appointments for the fracture clinic and plaster room. The service is for men, women and children of all ages. Most children's outpatients appointments take place in an area attached to the children's wards which is separate to the main outpatients department. Children are seen alongside adults for the specialities of ear, nose and throat (ENT) and fracture clinics which are located in the main outpatients areas. Specialties using main outpatients include respiratory, renal, cardiology, vascular, urology, breast, gastroenterology, general surgery, medicine and medical specialties. All other outpatient departments are specialty managed. These include:

- Ophthalmology.
- Ear, nose and throat (ENT).
- Maternity.
- Dental.
- Endoscopy.

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the Trust's activity through the main outpatients department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings. Outpatients is managed by the outpatients matron, outpatients manager and sisters.

During our inspection we:

- visited the main outpatient departments, phlebotomy, pre-operative assessment service, audiology, and the outpatient therapy clinics including physiotherapy and occupational therapy.
- spoke with 12 relatives and 18 patients.
- spoke with 42 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and triumvirate managers.
- looked at six sets of patient records in detail and observed several more.
- observed interactions between patients, relatives and staff.
- observed four patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Outpatients

Summary of this service

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- The service had enough nursing staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed most risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Most people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- The service did not always have enough medical staff provided clinic appointments for some specialities quickly enough.
- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. Remedial action for this was in progress. The service controlled infection risk well in all other areas.
- Not all patient consultation records were clear and fully legible.
- Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff conducting MCA assessments. Staff were not up to date with (MCA) training. The trust had a plan to remedy this.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

Is the service safe?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

Outpatients

- The service provided mandatory training in most key skills to all staff and made sure everyone completed it. This was an improvement since our last inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well in almost all areas. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing, medical and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was an improvement since our last inspection. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However,

- Staff were not up to date with mental capacity act (MCA) training. The trust had a plan to remedy this. Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff to conduct MCA assessments during the consultation.
- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. However, the service controlled infection risk well in all other areas.
- Not all handwritten patient records were clear and legible. However, detailed consultation outcomes were typed and added to the record after the appointment.

Is the service effective?

Not sufficient evidence to rate

We do not currently provide a rating for Effective. We found that:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and when they were delayed for a long time in the department.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Outpatients

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Most staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

However,

- Key services were not available seven days a week to support timely patient care. However, some clinics were provided at weekends to meet patient needs.
- Staff did not always fully support patients to make informed decisions about their care and treatment. Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, they followed national guidance to gain patients' consent.

Is the service caring?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good

This is the first time we have rated outpatients separately from diagnostic imaging.

We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers

Outpatients

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

However,

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

Is the service well-led?

Good

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a strategy developed with all relevant stakeholders. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress
- Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Most staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Most staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However,

- Staff did not feel valued or respected by senior leaders in the trust's executive team.

Outstanding practice

We found areas of outstanding practice;

Outpatients

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.
- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

Areas for improvement

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.
- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.
- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.
- Monitor that medical staff complete patient records in a clear and legible way.
- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.
- Consider ways to improve staff engagement with senior leaders and the executive team.

Royal Shrewsbury Hospital

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Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres. The trust employed 6,146 staff as of July 2019. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Summary of services at Royal Shrewsbury Hospital

Requires improvement 

Our rating of services improved. We rated it them as requires improvement because:

- The safe key question improved to requires improvement.
- Effective key question remained as requires improvement.
- Caring key question went down to requires improvement.
- Responsive remained as requires improvement.
- Well led key question improved to requires improvement.

Urgent and emergency services

Inadequate 

Key facts and figures

Urgent and emergency care services are provided from the Royal Shrewsbury Hospital (RSH) emergency department and the Princess Royal Hospital (PRH) emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a majors unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department.

Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

From March 2018 to February 2019, there were 121,442 attendances at the trust's urgent and emergency care services.

(Source: Hospital Episode Statistics)

The emergency department (ED) at RSH provides services 24 hours a day, seven days a week. At the time of this inspection, the ED at RSH consisted of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area.
- A triage room.
- A four bedded resuscitation bay. The resuscitation area was used for the treatment of trauma, those requiring treatment for life threatening illness or injury and those who require direct monitoring and immediate life/limb saving interventions.
- 12 majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A Clinical Decisions Unit (CDU) that could accommodate up to 10 patients. The CDU was a short stay inpatient area for ED patients only who require on-going observations, treatments and reviews where the main outcome is discharge from hospital within a 36-hour period.
- Three minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area that could accommodate up to four patients who were well enough to sit and await discharge or further assessment.
- A relatives' room.

Urgent and emergency services

- Two rooms that could be specifically utilised for the assessment and treatment of children.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider.

At the time of our inspection, work was in progress to build a room that could be used by patients who presented with acute mental health concerns.

Urgent and emergency care at RSH was previously inspected by the Care Quality Commission in August 2018. The service was rated as inadequate. A focussed inspection was also completed in April 2019. However, a rating was not awarded to the service due to the focussed nature of the inspection.

We carried out an unannounced inspection of the RSH emergency department from 18 to 20 November 2019 and 26 November 2019. We reviewed 29 patient care records and spoke with 12 patients and four relatives. We also spoke with 47 members of staff including, nurses, doctors, emergency nurse practitioners, therapists, healthcare assistants, receptionists, pharmacists, an associate nurse, a member of security staff, the ward manager, the matron, the head of nursing, the sepsis nurse, the audit manager, the quality improvement lead, the governance lead, and a dementia support worker. We also spoke with three staff who worked alongside the trust within the ED. This included paramedics and a member of staff from the mental health liaison team.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The service did not have enough permanent staff to care for patients and keep them safe. Staff were not always up to date with mandatory training. This included the training required to ensure staff knew how to protect patients from abuse. Staff did not always assess and manage safety risks well and lessons were not always learned following incidents. Emergency medicines were not always available, and medicines were not always stored securely. Accurate and detailed records were not always maintained or stored securely. Safety performance data was not clearly displayed for patients and staff to view.
- We could not be assured that clinical policies and pathways were based on national guidance and best practice. Managers monitored the effectiveness of the service, but appropriate and timely action was not always taken in response to poor audit findings. Managers did not always complete timely appraisals of staff's work performance and ongoing professional development and support was not consistently available to all staff. Effective systems were not in place to ensure people's dietary requirements were met and staff did not always give patients practical support and advice to lead healthier lives. Staff did not protect the rights of patients' subject to the Mental Health Act 1983 and they did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.
- The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always support people to understand the waiting times for assessment and treatment in the ED.
- The service did not plan care to consistently meet the needs of local people and the individual needs of patients. People could not always access the service when they needed it and they frequently had lengthy waits for treatment. Complaints were not always managed in accordance with trust policy.

Urgent and emergency services

- The service was not well-led. The required improvements from previous inspection had not been made. We identified ongoing and new Regulatory breaches. There was no ED specific vision or strategy and staff did not always feel respected, supported and valued. Information and governance systems were not effective. The service did not engage well with patients and the community to plan and manage services and the services approach to driving improvement was reactive rather than proactive.

However,

- The service mostly controlled infection risk well and managed clinical waste safely. Staffing gaps were filled with temporary staff. The majority of medicines were prescribed, administered and recorded appropriately and when things went wrong, staff apologised to patients and their relatives.
- Staff worked well as a team to benefit patients and some competency checks were in place to confirm that staff had the skills they needed to provide effective care. Staff sought verbal consent from patient's who could make decisions about their care and they gave pain relief when needed. Most ED services were available seven days a week.
- Individual staff members treated patients with compassion and kindness and provided emotional support to patients, families and carers.
- Managers and staff worked with others in the wider system and local organisations to plan care. Reasonable adjustments were made to help patients access the service.

Is the service safe?

Inadequate

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

- The service provided mandatory training in key skills. However, not all staff were up to date with this training.
- Staff were not always up to date with the safeguarding training that would enable them to consistently recognise and report abuse.
- Staff did not always keep equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment did not kept people safe.
- Staff did not always promptly identify and quickly act upon patients at risk of deterioration.
- Staff did not always complete risk assessments for each patient in a prompt manner.
- Staff did not always act to remove or minimise risks or update the assessments when risks changed.
- The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment.
- Detailed records of patients' care and treatment were not maintained within the ED. Records were not always clear, up-to-date or stored securely.
- The service did not have effective systems in place to ensure all medicines were stored securely and in line with manufacturer's guidance.
- Emergency medicines were not always available.
- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses.

Urgent and emergency services

- Systems were in place to support managers to investigate incidents and share lessons learned with the whole team and the wider service. However, incidents were not always effectively investigated in a timely manner to reduce the risk of potential harm from similar or repeated incidents.
- The service collected patient safety data. However, this information was not always up to date or clearly displayed for patients and staff to view.

However,

- The service mostly controlled infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection.
- Staff managed clinical waste well.
- Staffing gaps were filled with temporary bank and agency staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Systems were in place to ensure that the majority of medicines were prescribed, administered and recorded appropriately.
- When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- We could not be assured that clinical policies and pathways were based on national guidance and best practice.
- Managers completed some checks to make sure staff followed guidance. However appropriate and timely action was not always taken in response to poor findings.
- Staff did not protect the rights of patients' subject to the Mental Health Act 1983.
- We could not be assured that staff gave patients enough food and drink to meet their needs and improve their health as care records did not always evidence this.
- Effective systems were not in place to ensure that dietary adjustments could be made for patients' religious, cultural and medical needs. No formal nutritional assessments were in place to enable staff to assess and meet patient's individual dietary needs.
- Appropriate action was not always taken in response to poor findings from clinical audits, to make the required improvements and achieve consistent good outcomes for patients.
- Managers did not always complete timely appraisals of staff's work performance.
- Ongoing professional development and support was not consistently available to all staff.
- Staff did not always give patients practical support and advice to lead healthier lives.
- Staff did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.

However:

- Staff monitored the effectiveness of care and treatment.

Urgent and emergency services

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Some systems were in place to check that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide patient care.
- Most emergency department services were available seven days a week to support timely patient care.
- Staff sought the verbal consent of patients who were able to make decisions about their care and treatment.

Is the service caring?

Requires improvement 

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

- The service was not designed or delivered in a manner that respected patients' privacy and dignity.
- Staff did not always have the time to interact with people in a meaningful way.
- Staff did not always support people to understand the waiting times for assessment and treatment in the emergency department (ED).
- Patients were not consistently supported to feedback their experiences of care in the ED through the completion of the Patient Friends and Family Test.

However,

- Individual staff members treated patients with compassion and kindness.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff understood patients' personal, cultural and religious needs.
- When staff communicated with patients and their relatives, they did this in a manner that reflected peoples individual communication needs.

Is the service responsive?

Inadequate 

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

- The service was not designed to provide care in a way that consistently met the needs of local people and the communities served.
- The service and staff did not always meet the individual needs of patients, such as the specific needs of patients living with dementia.
- People could not always access the service when they needed to and they did not always receive the right care promptly.

Urgent and emergency services

- Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.
- Complaints were not always managed in accordance with trust policy.

However,

- Managers and staff worked with others in the wider system and local organisations to plan care.
- Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers when required.
- Systems were in place to enable people to give feedback and raise concerns about care received.

Is the service well-led?

Inadequate ➔➔

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

- Leaders did not have the skills and abilities to run the service in a safe and effective manner.
- Leaders did not understand and manage the priorities and issues the service faced.
- Senior leaders were not always visible and approachable in the service for patients and staff.
- The emergency department (ED) service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action.
- Staff did not always feel respected, supported and valued. Some staff reported a bullying culture within the ED and the wider trust and not all staff felt able to report incidents of alleged bullying.
- Leaders in the ED did not operate effective governance processes throughout the service and with partner organisations.
- Work pressures sometimes impacted on the staffs' capacity to regularly meet to, discuss and learn from the performance of the service.
- The service did not always identify, escalate and mitigate relevant risks and issues.
- The information systems were not integrated which meant staff could not always access patient data when they needed it.
- Some performance data was not shared accurately with other organisations.
- Leaders did not always actively and openly engage with staff and patient groups to plan and manage services.
- Increased patient demand in the ED prevented staff from continually learning and improving services.
- Staff told us leaders did not actively encourage innovation or participation in research.

However,

- Changes had been made that supported nursing staff to take on more senior roles within the ED.
- Staff at all levels were clear about their roles and accountabilities.
- The service collected some pertinent data and analysed it.

- Senior leaders engaged with stakeholders regarding the planning of future ED services.

Areas for improvement

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.
- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.
- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.
- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.
- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.
- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.
- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.
- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.
- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.

Urgent and emergency services

- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.
- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.
- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.
- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.
- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.
- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.
- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.
- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.
- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

The service SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.
- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.
- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.
- The service should continue to work with commissioners to improve ambulance handover times.
- The service should continue to embed local initiatives aimed to improve sepsis care.
- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.
- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.
- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.
- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.
- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.

- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.
- The service should explore how to effectively display patient safety information within the ED.
- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).
- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.
- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.
- The service should continue with the implementation of a suitable competency tool for staff working in the ED.
- The service should explore how to improve the training and development opportunities for middle grade medical staff.
- The service should continue to explore how allied health professions could provide a consistent seven-day service within the ED.
- The service should explore how they can make every contact count by offering health promotion advice and support to patients with risks that may affect their long term health and wellbeing.
- The service should consider how to evidence that consent has been sought and gained from patients within the ED.
- The service should consider how they can give accurate and up to date waiting time information to patients and their relatives within the ED.
- The service should explore how to improve patient participation in the Patient Friends and Family Test.
- The service should explore how they can make the ED more user friendly for all patients. This should include a review of the signage within the ED.
- The service should explore how the individual needs of people living with dementia could be met within the ED.
- The service should review the systems in place to improve the availability of information leaflets. This should include reviewing if there is a need to have information leaflets readily available in other appropriate languages and formats within the ED.
- The service should accurately report the numbers of patients leaving before being treated.
- The service should consider introducing a system to effectively monitor the time taken from referral to assessment in regard to the use of the mental health liaison team in the ED.
- The senior leadership team in the ED should explore how to improve their visibility and accessibility to staff and patients.
- The service should explore how the role of the band seven nurse within the ED can be improved to provide a consistent approach to the day to day co ordination the ED.
- The service should consider designing an ED specific vision and strategy outlining short and long term goals whilst the future fit project is in progress.

Urgent and emergency services

- The service should review the 2018 staff survey results and devise an appropriate action plan to address the alleged bullying culture within the ED and wider trust.
- The service should consider how they can evidence that the trust's major incident plan is well rehearsed by staff.
- The service should review the processes in place to enable them to send accurate information with other organisations as required.

Medical care (including older people's care)

Inadequate

Key facts and figures

Medical care is provided on both the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital Sites. Services provided on RSH site include: Nephrology (including Renal Dialysis unit), Respiratory, Cardiology, Endocrinology, Care of the Elderly (and Rehabilitation) as well as inpatient Neurology support and speciality outpatient clinics held in the Outpatients department, including Movement Disorders, Neurology, Dermatology and Diabetes.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we visited areas providing medical care in the service including: haematology and oncology, short stay unit, endocrinology, nephrology, general medicine, respiratory, the acute medical unit, the discharge lounge, coronary care unit, the renal unit, the frailty unit, acute medical unit and endoscopy. On our inspection we spoke with 33 members of staff including registered nurses, doctors, allied health professionals, pharmacists, healthcare assistants and the services leadership team. We spoke with nine patients and three relatives.

The care quality commission last inspected the service in September 2018 and rated the service as requires improvement overall. Safe, effective, responsive and well led were rated as requires improvement and caring was rated as good.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff completion data for mandatory training did not meet the trust targets.
- Infection prevention and control practices were not consistently adhered to within the hospital. Staff did not always wear appropriate personal protective equipment (PPE) and did not always wash their hands between patients.
- Staff completed venous thromboembolism risk assessments for each patient on admission but did not always review this regularly. We were not assured that risks to patients had been managed appropriately.
- Staff did not always follow systems and processes when safely prescribing medicines. We could not be assured that patients received the accurate drug dosing due to the weight not being recorded on medicine charts and the trust's electronic recording system.
- We were not assured staff used measures that limited patients' liberty appropriately and always knew how to support patients who lacked capacity, or who were experiencing mental ill health.
- Facilities and premises were not always appropriate for the services being delivered. The lack of appropriate facilities within the renal unit meant privacy and dignity could not always be maintained.
- We were not assured that the staff moved to other ward areas including escalation areas had necessary competencies to enable them practice safely.
- Governance systems were in place to monitor and assess risk but did not ensure risks such as compliance with mandatory training and infection prevention and control which had been identified during our inspection in September 2018 had been rectified.

Medical care (including older people's care)

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to staff, compliance was monitored but consistently did not meet the trust target.
- The service did not always control infection risk well. We could not be fully assured that infection prevention and control (IPC) practices were consistently adhered to. However, staff kept the premises visibly clean.
- Whilst staff assessed risks to patients and monitored their safety, they were not always completed for every patient when required. However, staff identified and acted upon patients at risk of deterioration.
- We were not assured that risk assessments were carried out for patients living with mental health conditions and attending the renal unit.
- The service did not always use systems and processes to safely prescribe medicines. However, they administered, recorded and stored medicines safely.
- The service did not have enough permanent medical, nursing, therapy and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. This had improved since our last inspection.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

Medical care (including older people's care)

- Staff did not always know how to support patients who lacked capacity, or who were experiencing mental ill health to make their own decisions and did not always use measures that limited patients' liberty appropriately. However, staff supported patients to make informed decisions about their care and treatment.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. However, staff protected the rights of patients' subject to the Mental Health Act 1983.
- Some key services were available seven days a week to support timely patient care. However, patients were not routinely reviewed by doctors at weekends.

However,

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff mostly monitored the effectiveness of care and treatment. They used the findings to make improvements and mostly achieved good outcomes for patients.
- The service made sure most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 

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

- Staff did not always take patients individual needs into account and did not ensure patients' privacy and dignity was always maintained. However, they treated patients with compassion and kindness.

However,

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

Medical care (including older people's care)

- The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, facilities and premises were not always appropriate for the services being delivered.
- Staff did not respond to complaints in a timely manner.
- Staff moved patients between wards at night and did not justify if the bed moves were for clinical or non-clinical reasons.

However,

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement

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

- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Governance processes in some areas were not embedded to ensure consistency across the service.
- The service did not have effective systems for planning to eliminate or reduce risks and coping with both the expected and unexpected.
- Most managers had the right skills and abilities to run the service providing high-quality sustainable care. However, new changes required after a death on the renal unit had not always been implemented.

However,

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, staff morale was sometimes low due to being moved to provide cover during staff shortages.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems.
- The service engaged well with patients and their relatives to plan and manage appropriate services.
- The service was committed to improving services by learning from when things went well and when they went wrong and promoting innovation.

Medical care (including older people's care)

Areas for improvement

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.
- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.
- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.
- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.
- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.
- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.
- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

The service SHOULD take action to:

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.
- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

Surgery

Requires improvement ➔➔

Key facts and figures

The surgery core service provides care and treatment for specialties including breast surgery, colorectal surgery, ear nose and throat (ENT), head and neck, ophthalmology, upper gastro-intestinal surgery, urology and vascular surgery.

(Source: Routine Provider Information Request AC1 - Acute context)

Surgical services are provided on both the Royal Shrewsbury Hospital (RSH) and The Princess Royal Hospital (PRH) sites.

RSH surgical admissions unit accepts all surgical emergency patients referred by GPs and admitted from the emergency departments at both RSH and PRH sites. RSH is a designated trauma unit.

The surgery core service at this hospital provides care and treatment for specialties including colorectal surgery, upper gastro-intestinal surgery, urology and vascular surgery. In addition, ears, nose and throat (ENT) and ophthalmology day case surgery is carried out at this site.

Royal Shrewsbury Hospital has nine operating theatres and 119 surgical inpatient beds located across four wards and units:

Ward/unit	Specialty or description	Inpatient beds
Day case ward	**General surgery**	**16**
Surgical assessment unit & short stay surgical unit	**General surgery**	**38**
Ward 22	**Trauma & orthopaedics**	**29**
Ward 26	**Vascular and urology**	**36**

(Source: Routine Provider Information Request AC1 - Acute context)

RSH, Shrewsbury and PRH, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the same scheduled care group across the hospitals and had the same clinical directors.

This evidence appendix relates to surgery services provided at RSH, Shrewsbury, which provided both elective and emergency surgery.

Surgical services at RSH was previously inspected by the Care Quality Commission in August. The service was rated as requires improvement, although caring was rated as good.

During our unannounced inspection from 18 to 20 November 2019 and 02 December 2019, we visited all areas providing surgery services at the hospital, including the surgical assessment unit and short stay ward, pre-assessment, the day case unit and short stay ward, and two surgical wards, theatres and recovery. We spoke with 11 patients and observed

Surgery

patient care and treatment. We reviewed 18 patient care records and 10 medicine administration records. We spoke with 42 members of staff including nurses, doctors, anaesthetists, surgeons, therapists, healthcare assistants, housekeeping staff, theatre practitioners, ward managers, matrons, pharmacists and dementia care assistants. We also interviewed some members of the senior management team within the scheduled care group.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed mandatory training did not meet trust targets.
- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with children and young people under 18 in theatres, did not have the correct level of safeguarding training.
- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.
- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.
- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were not always clear and up-to-date and were not always stored securely.

However,

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.
- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Surgery

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service safe?

Requires improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.
- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with young people under 18 in theatres, did not have the correct level of safeguarding training.
- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.
- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.
- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.
- Records were not always clear and up-to-date and were not always stored securely.

However,

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.
- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Surgery

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service achieved mixed outcomes for patients. Plans were in place to improve this.
- Managers did not hold supervision meetings with staff to provide support and development.
- Appraisal rates did not meet trust targets.
- Multidisciplinary meetings were not consistently held across all specialities.
- There was very low staff compliance with mandatory training in Mental Capacity or Deprivation of Liberty Safeguards.

However,

- Staff monitored the effectiveness of care and treatment.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Most staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Requires improvement ➔

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

- Staff did not always demonstrate they respected the privacy and dignity of patients who stayed overnight in the surgical assessment unit.
- Staff did not always demonstrate empathy in delivering bad news to patients in a private space.

However,

- Staff treated patients with compassion and kindness and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Capacity did not meet the demand of the service and patients were boarded on the surgical assessment unit to accommodate them.
- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Complaints were not always responded to in a timely manner and the service took longer to investigate than the trust average. The average days it took to investigate was more than our previous inspection in 2018.

However,

- We saw the service planned and, in most cases, provided services in a way that met the needs of local people.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- Managers were not always available out of hours and leaders were not always visible and approachable in the service for patients and staff.
- The strategic priorities of the service did not demonstrate they were aligned to local plans within the wider health economy.
- Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.
- We were not assured the service identified all risks. Risks had been on the risk register for long periods and did not always demonstrate they were being effectively managed to reduce their impact. Not all risks we identified during our inspection were on the service risk register.

Surgery

- The service collected reliable data and analysed it, however, systems did not provide managers with information to assess volume and waiting times of patients attending the surgical assessment unit.
- The service had not made significant improvements within surgical services at the Royal Shrewsbury Hospital following our previous inspection in 2018.

However,

- Most leaders had the skills, knowledge and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt increasingly respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.
- Leaders and teams used systems to manage performance. Systems were in place to identify and escalate risks and issues.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff engagement with patients, staff, the public and local organisations to plan and manage services was improving. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Most staff had a good understanding of quality improvement methods and the skills to use them.

Outstanding practice

We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.

Surgery

- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.
- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.
- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.
- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.
- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.
- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.
- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

The service SHOULD take action to

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.
- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.
- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.
- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.
- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.
- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.
- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.
- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.
- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.

Surgery

- The service should consider reviewing management staffing out of hours to support the provision of seven day working.
- The service should review the process for providing agency staff with immediate access to electronic records and systems.

End of life care

Requires improvement 

Key facts and figures

The trust provides end of life care at two of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, four ward managers, four ward sisters, one staff nurse, one nurse associate, one healthcare assistant, the head of pathology, the mortuary manager, the bereavement manager, three administrators, three porters, one end of life care volunteer, five patients and three family members. We also reviewed ten care records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always keep good care records.
- Key services were not available seven days a week. Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not audit fast track discharges and achievement of preferred place of care and death.
- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information.

End of life care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.
- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff used infection control measures when visiting patients on wards and transporting patients after death.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- Records were stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

End of life care

Is the service effective?

Requires improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Good

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement

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

End of life care

- The service did not audit fast track discharges and waiting times from referral to achievement of preferred place of care and death.

However;

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 

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

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.
- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.
- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

Areas for improvement

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

End of life care

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing
- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.
- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.
- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.
- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Requires improvement

Key facts and figures

Outpatient services at Shrewsbury and Telford Hospital NHS Trust are provided across two hospital sites, The Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital.

The central outpatient function is managed by the Scheduled Care Group with the exception of the fracture clinic which is managed by the Unscheduled Care Group.

While some outpatient facilities for children are provided alongside those for adults, children's outpatients provision is not included in this section of the report. Similarly, outpatient provision for maternity services is excluded.

At the Royal Shrewsbury Hospital there is a central outpatients facility that covers cardiology, urology, breast, gastroenterology as well as general surgical and medical specialties.

There are separate departments for:

- Ophthalmology (Eye Clinic).
- Surgical Pre Assessment.
- Fracture Clinic.
- Endocrinology.
- Renal.
- Phlebotomy (blood samples).

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the trusts' activity through the main outpatient department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury Hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings.

During our inspection we:

- visited the main outpatient department, phlebotomy, surgical pre assessment, the eye clinic, the fracture clinic, the endocrinology clinic and the renal clinic.
- spoke with 4 relatives and 12 patients.
- spoke with 28 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and managers.
- looked at 8 sets of patient records.
- observed interactions between patients, relatives and staff.
- observed two patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and usually managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Most people could access the service when they needed it and did not wait too long for treatment. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- There were not enough clinic rooms in some areas and this resulted in patients not being seen.
- In one area assessment rooms were too cramped or poorly lit for safety
- Staff did not have the training they needed to support patients who lacked capacity to make their own decisions.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.
- Information system were not integrated with one another relying on duplication of data entry and many systems were paper based.

Is the service safe?

Requires improvement

We rated it as requires improvement because:

- There were shortfalls in training for fire safety and infection prevention and control.

Outpatients

- There were concerns in the eye clinic about the suitability of the lighting and the equipment fit in some rooms. There was also an insufficient number of clinic rooms available in some areas to accommodate the demand.
- Equipment, while cleaned between patients, was not always labelled as such.

However

- The service provided mandatory training in key skills to all staff and made sure most staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment usually kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and usually available to all staff providing care. While there were continuing problems with the central records store which caused difficult in finding records, the trust had a costed and approved plan to address them. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

We do not currently provide a rating for effective

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Outpatients

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff followed national guidance to gain patients' consent.

However:

- However, because of changes to training arrangements the trust could not be assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good

We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

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

Is the service responsive?

Requires improvement

We rated it as requires improvement because:

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

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Outpatients

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

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and most had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams managed performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected data and analysed it. The information systems were secure.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

However:

- However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not well integrated across the organisation.

Areas for improvement

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.
- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

Outpatients

The service SHOULD take action to:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.
- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.
- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.
- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.
- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Maternity and midwifery services	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29A Warning Notice: quality of healthcare
Diagnostic and screening procedures	
Family planning services	
Management of supply of blood and blood derived products	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Treatment of disease, disorder or injury	S31 Urgent variation of a condition

Our inspection team

Bernadette Hanney, Head of Hospitals Inspection, led this inspection. An executive reviewer, Susan Field, Director of Nursing, Gloucestershire Health and Care NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included 17 inspectors and 38 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Royal Shrewsbury Hospital

Quality Report

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

Date of inspection visit: 17 February 2020
Date of publication: 08/04/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at Royal Shrewsbury Hospital on 17 February 2020, in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. We also undertook an unannounced inspection of Princess Royal Hospital, Telford on 18 February 2020 which has been reported separately.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however we have rated this service in accordance with our enforcement policy.

This was a focused inspection to review concerns relating to the emergency department. It took place between 12pm and 8pm on Monday 17 February 2020.

We found:

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

Staff did not consistently apply control measures to protect patients, themselves and others from infection risks.

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

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

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

Staff did not always feel respected, supported and valued.

Importantly, the trust must:

Action the hospital MUST take to improve

Ensure that staff comply with nationally recognised infection control standards.

Summary of findings

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable.

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children.

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales.

Ensure patients can access care and treatment in a timely way.

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway.

Ensure patients requiring time critical medicines are clinically assessed and such medicines are prescribed and administered in a timely way.

Ensure patients are treated with dignity and their privacy is always protected .

Ensure patients are managed in an environment which is fit for purpose.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to Royal Shrewsbury Hospital

We carried out an unannounced focused inspection of the emergency department at Royal Shrewsbury Hospital in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. As a result of this inspection, we took the decision to rate the service based on us issuing requirement notices. We rated the safe, caring, responsive and well-led domains as inadequate. The service was therefore rated inadequate overall.

We previously inspected the emergency department at Royal Shrewsbury Hospital in November 2019. We rated it as inadequate overall. Following this inspection, we initially considered using our urgent enforcement powers due to significant concerns we had over the health and safety of patients in the department. In accordance with guidance issued by the National Quality Board (NQB) and in response to our concerns, system wide risk summits were held on 13 December 2019, 21 January 2020 and 25 February 2020. Risk summits provide a mechanism for key stakeholders involved in the system-wide delivery of health and/or social care to come together to share and review information when a serious concern about the quality of care has been raised. Risk summits enable those organisations to facilitate rapid, collective judgements about the quality of a service and to agree actions needed because of the risks identified.

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

- The trust has 721 acute beds (+9% from June 18), 22 critical care beds (+5% from June 18) and 37 maternity beds (0% change).
- From March 2018 to February 2019, there were 123,851 inpatient admissions (+8% compared to previous year). 9,068 of these were children, approximately 8.6% of all admissions.
- There were 718,882 outpatient attendances (+12% from previous year).
- There were 121,442 accident and emergency department attendances (+9% from previous year).
- The trust employs 5,108 WTE staff.

Our inspection team

The team that inspected the service comprised of CQC inspector, a national professional advisor with expertise in urgent and emergency care, an emergency care consultant, an emergency department nurse and an emergency department matron specialist advisor. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Information about the service

The emergency department (ED) at Royal Shrewsbury Hospital RSH) provides services 24-hours per day, seven days per week service.

The ED at RSH consists of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area.
- One triage room (a second triage room was being created at the time of the inspection)
- A four bedded resuscitation bay.
- 12 majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A four bed 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A clinical decision unit (CDU) that could accommodate up to 10 patients. The CDU was a short stay inpatient area for ED patients only who require on-going observations, treatments and reviews where the main outcome is discharge from hospital within a 36-hour period.
- Three minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area that could accommodate up to four patients who were well enough to sit and await discharge or further assessment.
- A relatives' room.
- Two rooms that could be specifically utilised for the assessment and treatment of children.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider and therefore did not form part of this inspection.

During the inspection, we visited the emergency department only. We spoke with 19 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with eight patients and three relatives. During our inspection, we reviewed 59 sets of patient records.

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- The design of the environment did not follow national guidance. For example, national guidance aimed at providing a safe environment for children presenting at an ED was not being followed. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was also not being followed. For example, this guidance states that children's areas should be monitored securely and zoned off with access control to protect children from harm, including the ability to contain someone who may want to leave the department against clinical advice. The children's waiting area was not secure or zoned off as required. It was located off one of the hospital's main corridors and was also very accessible from the nearby main ED waiting area and the nearby fracture clinic. During the

Urgent and emergency services

inspection, we spent periods of time observing both the children's waiting area and the main waiting area. There was a consensus among nursing staff that children were not routinely directed to the children's waiting area due to it having very poor line of sight away from clinical staff. We observed one occasion when four children were present in the main waiting room which was occupied with adult patients; one of whom was a detained patient who was handcuffed to prison security staff.

- National guidance relating to provision of a safe environment for patient's presenting at the ED with acute mental health concerns was not followed. The July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. At the time of our inspection, a new room had been commissioned however the room did not meet national standards. Although there were two doors which had been fitted with anti-ligature handles, the door closes were not of an appropriate design. Further, the door frames had not been fitted with anti-barricade mechanisms. Light weight furniture including a general waste bin was in the room which afforded patients items which could be thrown or use as a means of barricading internally opening doors. Air ventilation shafts were present in the room, suggestive of pipework being present above the false, non-secured ceiling tiles; such pipework and other ancillary equipment posed ligature risks. We raised this with the director of nursing who reported the room had been reviewed by members from the mental health service who confirmed the room was fit for purpose. The director of nursing reported they would act to resolve the issues identified at the time of the inspection.
- The ED premises were outdated and did not meet the April 2013 Health Building Note 15-01: Accident & emergency departments Planning and design guidance as the ED's building date preceded this guidance.
- The ED environment was not secure and did not protect patients from being accessed by people who may pose a threat to their health and wellbeing. Equipment was also not protected from being accessed and tampered with or stolen. Throughout our inspection, all areas of the ED were easily accessible to all staff, patients and visitors. People were able to freely access areas including the resuscitation bay where seriously ill patients were located.
- Because of bed capacity challenges at the trust, patients were regularly and routinely cared for in the ED corridors. This meant corridors were cluttered and left reduced space for staff and patient movement in the event of an emergency. During the inspection, 16 patients were being cared for along corridors. Patients did not always have access to call bells to alert staff in the event they required assistance. We spoke with four patients who were being cared for along the corridor. They reported they relied on waiting for a member of staff to pass by or had to ask a relative or call out for help. This meant there was an inherent risk in that those patients who may feel acutely unwell or who were at risk of rapidly deteriorate, may not be able to call for immediate help.
- The CDU had previously been established by the trust on the advice of national partners including the Emergency Care Intensive Support Team (ECIST) in response to an increasing demand and to manage severe departmental overcrowding during the winter of 2018/19. However, the CDU did not meet any national service specification and was not fit for purpose. This was recognised by the acting clinical lead as an area of concern. They acknowledged there were benefits to having the area which could be redeveloped as a frailty unit, however this had not progressed. Staff reported there was a general acceptance of the poor environment which posed risks to patients and staff.
- We had previously reported patients in the clinical decision unit had limited access to call bells. Patients who were located outside of a trolley/bed space in chairs did not have access to call bells and we saw that one vulnerable patient who did occupy a trolley/bed had their call bell within reach however the cable had been disconnected from the wall. This meant the patient was unable to call for help despite being in a vulnerable state and being nursed behind closed curtains.
- The clinical decision unit was historically two separate head and neck operating theatres. The two areas were split to provide single sex accommodation. Both rooms were divided by disposable curtains, and staff reported three patients could be managed in each area. During the inspection, five patients were allocated across the

two rooms. Each bed space was extremely small. There were no toilet or shower facilities and hand washing facilities were limited to existing surgical hand scrub sinks. There was no space for nursing staff to store or prepare medication. We noted one patient's medicines were stored on the desk located between the two CDU rooms, allowing easy access from members of the public to remove them. Nursing staff were required to leave the CDU area in the event they were required to prepare medicines, therefore leaving the area unsupervised for periods of time, as was observed during the inspection.

- There was no fixed piping to provide oxygen or suction. There were two portable suction units available in the clinical decision unit. Nursing staff reported oxygen could be provided via oxygen cylinders which were installed on the trolleys used in the department. However, we noted one patient was being nursed on a bed which did not have space for a portable oxygen cylinder. Nursing staff working in the CDU confirmed that whilst there was no resuscitation trolley available in the CDU there was one located directly outside in the main corridor; this trolley had been regularly checked and was equipped with a portable automated electronic defibrillator, airway adjuncts and venous access equipment, as well as medicines used as part of advanced life support management. A foundation year doctor who was present in the CDU was not aware of the location of the nearest resuscitation trolley. We asked nursing staff covering the area the location of the nearest; they were able to direct us to the trolley located in the corridor located adjacent to the majors area.
- Staff had access to sepsis trolleys. These are ready made boxes which include sepsis step by step guidance and all the items required to deal with a suspected sepsis patient quickly, for example fluids. We randomly sampled equipment on the trolley and found all items to be in date.

Cleanliness, infection control and hygiene

Staff did not consistently apply control measures to protect patients, themselves and others from infection risks

- During the inspection, five patients in the ED were source isolated due to conditions including norovirus and Clostridium difficile. These patients were nursed in side rooms to reduce the spread of infections; this was consistent with best practice standards. However, there were no signs on the doors to alert staff or visitors to the infection control precautions which should be adopted to safeguard individuals and other patients. We observed multiple episodes of care whereby staff did not routinely adopt personal protective equipment, nor were hands decontaminated before and after contact with these isolated patients. This posed a risk to other patients, staff and visitors.
- We observed a further episode of care during which a nurse inserted a peripheral venous cannula in a patient without adopting any form of aseptic non-touch-technique. This was contrary to best practice standards.
- There were multiple occasions when staff were observed not washing their hands either before or after having had physical contact with patients or soiled materials.
- There were not enough handwash basins across the departments to enable staff easy and timely access to decontaminate their hands between patient contacts. Health building note 00-10 requires all clinical wash-hand basins be installed in all clinical areas. The sink and taps present in the pit stop area did not meet these requirements.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

- National guidance relating to the initial assessment of patients who presented at the ED was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. A triage and streaming system was in place that aimed to prioritise patients, so they could receive the right care at the right time in the right place. After booking in at reception, patients were called to talk to the streaming

nurse at a window at the ED reception. The streaming nurse asked clinical questions and identified patients who could be seen at the urgent care centre (another service based on site but managed by another provider). They also allocated patients to a triage queue or directed patients straight to resus if they had very urgent care needs. Following concerns identified at previous inspections, we imposed regulatory conditions of the trusts' registration which required them to operate an effective triage process. This was to enable better awareness among staff as to the clinical acuity of patients who self-presented to the department.

- The trust was legally required to submit information on a routine basis detailing how they were meeting these conditions and to explore any potential harm caused to patients who may not have been initially assessed within a timely way. We used this information as a means of gaining assurance that patients were being clinically assessed within an appropriate timeframe. However, we noted during an inspection of the service in November 2019 that there was ambiguity as to the time being recorded on the patient's CAS card, which was used by local leaders to compile the section 31 returns. Staff reported that once a patient had seen the streaming nurse, this time was recorded on the CAS card. However, due to the nature of the mixed streaming/triage process used in the department, the streaming nurse was not able to clinically assess a patient as they had no location to undertake vital sign observations to facilitate an appropriate triage assessment. Whilst those patients who looked extremely unwell could be expediated to majors, or to the resuscitation room, those patients who presented with mild symptoms of chest pain, or had underlying deranged vital signs for example, may not have been so easily detected, especially if a patient was in a clinically compensated state (the body has inherent survival mechanisms which are triggered during periods of critical illness for example. These processes are often only sustainable for short periods of time, and once exhausted, the body succumbs to the symptoms of the underlying illness. This compensatory mechanism can initially mask the actual acuity of a patient and can mislead health professionals if the underlying cause is not quickly identified, resulting in patients rapidly deteriorating). The trust subsequently reported they only monitored the time it took from patients booking in to being streamed, rather than the time from booking in to triage. Trust data showed the average time to streaming between August 2018 and October 2019 was 20.5 minutes. This meant the trust was consistently not meeting the 15-minute triage standard for adults. On 17 February 2020 we observed there to be limited numbers of patients self-presenting to the emergency department. This meant patients experienced minimal waits between booking in with reception staff and being seen by the streaming nurse. We observed one example whereby a patient who appeared acutely unwell was transferred direct to the resuscitation room once they had been seen by the streaming nurse.

- However, during the inspection we observed the streaming and triage process and whilst there were minimal waits for patients to be seen by the streaming nurse, patients referred to be seen by the triage nurse often waited periods of 18 minutes or more before they had a set of observations completed; this was despite the waiting room being relatively quiet on the day of the inspection. Staff reported it was not unusual for the triage nurse to be redeployed to other parts of the department, resulting in less experienced healthcare support workers undertaking the triage process. This was observed to be the case on the day of the inspection. We noted on one occasion a patient had a delay of one hour 29 minutes between being streamed and being called to see the triage nurse. A second patient had waited 33 minutes during a period of low activity. This suggested that when busy, patients could expect to wait extended periods of time before nursing staff could ascertain a baseline for the patient, to aid the developing an appropriate triage protocol.
- We further noted concerns with the use of triage categories in the absence of vital signs being readily available to the streaming nurse. For example, one was triaged as a category green (clinical review within two hours) despite the triage nurse recording an initial early warning score of nine. This would have placed the patient as a category one (immediate clinical review). The patient waited one hour from time of arrival to being clinically assessed by a senior clinical decision maker. This meant there remained a risk the most critically ill patients may have been delayed in being clinical treated by a senior decision maker.

Inadequate

Urgent and emergency services

- We had previously raised concerns that patients arriving by ambulance were often delayed in being clinically assessed and handed over. This meant there was a risk acutely unwell patients may not have received time critical care and treatment. To address ongoing challenges, the trust had previously created a four-bed pit-stop area. This area was used to allow for patients arriving by ambulance (and on occasion, patients who self-presented who appeared extremely sick) to be rapidly assessed by a senior nurse. During this inspection, we observed this process working well. Patients were received, in general, in a timely way by the pitstop nurse. Clinical interventions including electrocardiograms (ECGs), blood tests and other assessments were carried out quickly. We observed instances when the nurse was sufficiently concerned about the condition of a patient and subsequently escalated the patient to medical staff who then carried out timely assessments of patients.
- In the period leading up to and during Christmas 2019, the hospital was experiencing high numbers of ambulances which were delayed by more than 60 minutes from arrival to handing over patients. Data shows peaks and troughs in the number of ambulances delayed during this time period ranging from five to 28 ambulances each day. There was then sustained improvement between 15 January 2020 and 29 January when fewer than five ambulances were delayed daily. Peaks in activity were then noted thereafter with up to 15 ambulances delayed by more than 60 minutes, daily. During the inspection, ambulances were offloaded, and patients handed over in a timely way. However, staff reported that there were occasions when ambulances were required to cohort their patients, or experienced delays in handing their patients over. We asked staff to describe the process for providing clinical oversight and to outline the assessment pathways for patients who were cohorted and who could not be handed over. We were told there was currently no standard operating procedure for the oversight of the ambulance queue. Nursing and medical staff reported they would not routinely review those patients in the ambulance queue unless a paramedic or technician were concerned about the patient and therefore escalated their concerns to the nurse in charge. This presented a significant clinical risk and was contrary to national guidance issued by NHS Improvement in 2017 ("Addressing ambulance handover delays: actions for local accident and emergency delivery boards"). This mandates that "The patient is the responsibility of the ED from the moment the ambulance arrives outside the ED, regardless of the exact location of the ambulance".
- Medical staff had been assigned a sepsis bleep and the bleep numbers was displayed throughout the department. Staff reported the individual carrying the sepsis bleep was required to wear an orange arm band which provided a visual alert for staff in the department. However, during the inspection, we observed the armband to be stored at in a box at the majors control hub.
- Nursing staff had access to nationally recognised risk assessment tools including the national early warning scoring system (NEWS2), Waterlow skin risk assessment tools and sepsis six care bundles. The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were designed to help clinical staff to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Whilst staff were commencing sepsis screening tools for patients, they did not consistently follow trust protocols. We noted examples where the working diagnosis of patients was sepsis despite staff having initially screened the patient as being low risk, and despite their being single parameters of two or more at initial assessment. There was sporadic use of the NEWS2 tool. Where patients had met the criteria for hourly monitoring, as part of the NEWS2 escalation and management protocol, there was sporadic compliance noted from the comprehensive review of the clinical notes we considered during the inspection. This included one patient who presented with generalised weakness; their initial early warning score was recorded as four. A sepsis screen had been completed which marked the patient as being at low risk despite the EWS flagging two in one single parameter; this should have prompted nursing staff to continue the sepsis screen to rule out any potential red flags. Two hours after arrival, the patient was clinically assessed where it was identified the patient had a red flag for sepsis (high lactate). The sepsis bundle was subsequently completed two hours after arrival. However, antibiotics which had been prescribed on commencement of the

second review of the sepsis bundle were not administered for another two hours (four hours after arrival to the ED). This was contrary to best practice standards.

- We further noted delays in the administration of medicines; national early warning scores completed infrequently and contrary to trust protocol; and patients identified as being at high risk of pressure damage through Waterlow skin assessments, remaining on trolleys for extended periods of time with no active mitigations. This included one elderly patient who had been recognised as being at very high risk of skin damage, in part due to already having a sacral pressure ulcer, remaining on an assessment trolley for 22 hours. Nursing documentation was poor and did not describe the routine skin care provided to this patient. This was contrary to national guidance which states: The National Institute for Health and Care Excellence, Clinical Guideline 179: Pressure ulcers: prevention and management recommend that patients identified as being at "High risk" should be supported to be repositioned every four hours and that the frequency of repositioning should be recorded. Another patient was at "Very high risk" which would therefore suggest the patient should be repositioned more frequently to reduce the likelihood of them sustaining pressure damage. We raised our concerns about this patient with the senior nurse, the nurse-in-charge and the clinical site team. The initial response from one senior member of staff, when we highlighted the fact the patient already had a grade two pressure ulcer was "It will probably be a grade three ulcer now". We considered this to be an extremely poor response from a senior member of staff. On our escalation, the patient was subsequently found a side room on a ward and was transferred from the ED.

- A second patient had also been identified as being at very high risk of skin damage, with a Waterlow score of 20. Again, this patient remained on an assessment trolley with no additional protective measures in place for a period of 22 hours. Again, there was no routine documentation to demonstrate how nursing staff had met the needs of the patient through regular repositioning and skin care being provided.

- One patient had been admitted to the clinical decision unit during the early hours of 17 February 2020. The patient was categorised as being vulnerable due to having learning disabilities. Clinical staff had identified the patient has having previously been diagnosed with Parkinson's disease, for which they were time critical medicines to help manage their symptoms. We noted that despite there being a contemporaneous note of the diagnosis, staff had not considered sourcing or prescribing the time critical medicines for the patient. When inspectors met with the patient, they noted the patient to have significant tremors. Fortunately, a frailty consultant had also identified the patient and took swift action to prescribe their time critical medicines. When we met with the patient later in the day, their tremors had stopped, and the patient was more comfortable. We found other occasions whereby acute medics were prescribing regular medicines for patients who were being held in the ED due to a lack of beds in the hospital. However, nursing staff were not consistently sourcing those regular medicines, therefore impacting on individual patient's drug therapies. This was not recognised as an area of concern by the local leadership team, who attributed failings in care to poor hospital flow. Fundamentally, the lack of comprehensive nursing care could have impacted negatively on the safety and welfare of patients who experienced extended stays in the emergency department. We asked the member of staff responsible for caring for the patient with Parkinson's disease, whether the omission to prescribe and administer time critical medicines had been reported as a clinical incident in order that future incidents could be prevented. They reported they had not been able to report the incident due to time constraints. This was a missed opportunity for the department to learn from a significant event and therefore posed risks to other patients who may present with chronic conditions for which they require time critical medicines to control symptoms.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

- The service did not have had enough permanent nursing staff to keep patients safe. There was a very high reliance on temporary bank and agency staff. This was

observed to be the case during the inspection. We spoke with four agency nurses, some of whom had been allocated a set block of shifts to support the ED. Each agency nurse reported they were familiar with the department. They could describe the actions they would take in the event a patient deteriorated, including the use of the NEWS2 system, as well as being able to identify the location of resuscitation trolleys. Although agency staff did not have access to electronic systems, therefore hindering their ability to view x-ray reports for example, each agency nurse could describe who they would liaise with to gain access.

- Local leaders reported they had completed a baseline staffing assessment to determine the numbers of nursing and health support workers required to safely manage the department. It was reported this assessment was carried out using the Royal College of Emergency Medicine Baseline Emergency Staffing Tool (BEST). The local nurse manager reported there had been a reduction in the number of nurses deployed during the day from 16 to 12. They reported nursing staff were allocated as follows for day shifts

- 1 nurse was supernumerary as department co-ordinator
- 1 nurse streaming
- 1 nurse in resuscitation
- 1 nurse in clinical decision unit
- 1 nurse in pit stop
- 2 nurses to support the corridor
- 1 nurse in triage
- 3 nurses to support the major's cubicles.
- 1 nurse allocated to care for children.
- The BEST tool uses a range of predefined patient dependency ratios to determine the number of staff required each shift. The local leadership team were not able to confirm whether these criteria had been used as part of the BEST assessment as only one nurse was assigned to the four bedded resuscitation area. BEST recommends that a patient who meets the criteria for total dependency requires two nurses to care for them, whilst a patient who was high dependency should expect to receive one to one nursing care. These assessments and ratio's were based on a validated patient acuity tool. We explored further the nurse establishment assessment to ascertain exactly the basis on which it was carried out. It was not clear from the number of nurses deployed across the department, how a baseline assessment of 12 nurses during the day, reducing to ten overnight had been based. This was on the basis that patients in the resuscitation area were or could be extremely unwell, and thus meet the criteria for high or total dependency. Nursing staff reported the resuscitation area was regularly full with four patients and that at times, extremely sick patients required significant nursing and medical intervention however only one nurse and one healthcare support worker was assigned to the area.

- We observed during the inspection that at times of extremely high acuity and department activity, the triage nurse was moved to support the resuscitation room, having been replaced with a healthcare support worker. An agency nurse who had been assigned to provide care to six patients along the corridor had also been informed they were likely to be moved to the resuscitation area, therefore leaving two nurses to provide care to 16 patients in the corridor, with the support of one health support worker. As the day progressed, there was no requirement to move the agency nurse from the corridor, however staff reported they did not consider the staffing ratio's to be correct which impacted on their ability to provide effective nursing care.
- During the inspection we observed the clinical decision unit to be unattended despite there being five patients allocated across the two rooms. This included one patient who was receiving intravenous antibiotic and fluid therapy, and who had been found by inspectors in a state of unkemptness and having been incontinent of urine.
- The trust reported they required 14 Band Seven nurses, 63 band six, 53 band five and two practice development nurses to safely staff both emergency departments. At the time of the inspection, there were four vacant band seven posts (29% vacancy rate); 23 band six posts (36.5% vacancy rate), 39 band five posts (73.5% vacancy rate) and both practice development roles were also vacant (100% vacancy rate). The trust reported adverts for the band seven roles had attracted 11 applications with ten individuals shortlisted for interview. 12 applications had been received for the band six roles with nine individuals shortlisted for interview. Eight individuals were shortlisted for interview on 27 February 2020.
- The trust reported they were undertaking an extensive overseas nurse recruitment campaign directed at closing the high band five vacancy gap. Six nurses had

arrived in to the UK on 5 December 2019 who were shortly followed with an additional 48 nurses. Six nurses had undertaken their observational scenario clinical examinations to enable them relevant registration with the Nursing and Midwifery Council, and therefore the legal ability to work in the UK as a nurse. A further nine nurses were scheduled to undertake the OSCEs on 14 February 2020. The trust anticipated that by May 2020, 106 overseas nurses would have arrived. A further overseas pipeline of OSCE ready nurses had recently been interviewed from which 28 had been identified as being suitably competent to work in the emergency departments across the trust.

- As at December 2019, the trust reported that of the 9,816 total nursing care hours required to provide care and treatment, 591 hours had remained unfilled. Despite the use of temporary staffing, this meant the department remained understaffed by 3.6 whole time equivalent nurses through December 2019.
- In total, 47% of care hours were covered through temporary staffing arrangements, 6% of care hours were unfilled, and 46% were covered through substantive staffing arrangements. 20% of care hours in December were covered through block-booked agency staff; 14% through adhoc agency and 13% supported through bank staff cover.
- The trust did not have enough children's nurses to meet the June 2018 Royal College of Paediatrics and Child Health guidance, Facing the Future: Standards for children in emergency care settings. There were not enough children's nurses employed by the trust to ensure two children's nurses were available on each shift. An ongoing recruitment programme was in place to try and address this. The Care Quality Commission recognises the challenges of recruiting enough numbers of qualified and competent children's nurses to provide continuous emergency care services which meet the RCPCH standards. This is also recognised as a challenge within the standards themselves. However, providers must ensure they recruit and deploy enough numbers of staff with the right skills, training and competency to provide safe and effective care. The standards state that providers should ensure that where there are recruitment challenges, it is essential that a flexible workforce is developed whereby staff are competent and safe to care for infants, children and adults and that this should include emergency care skills.
- We asked local leaders whether adult nursing staff had received any additional training or completed recognised competency frameworks to help them to care for infants, children and young people. We were informed that no such competency framework existed at the trust. We raised this as a significant area of concern with the trust executive team. They subsequently reported they were acting to ensure there were enough numbers of nursing staff each shift to meet the needs of children. We continue to monitor this closely with the trust and system partners and will take appropriate action if we identify further concerns.

Medical staffing

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

- The service did not have had enough permanent medical staff to keep patients safe. There was a very high reliance on agency and locum staff. The trust was commissioned to provide type one and type two emergency care services across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed six whole time equivalent consultants against an anticipated establishment of 20. However, because of long term sickness and maternity leave, only four consultants were available across the two emergency departments to provide consultant presence.
- There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies).
- An interview had been scheduled for 24 February 2020 for one candidate for the role of substantive consultant.
- The department was supported by four further locum ED consultants who had been booked until at least March 2020; a further one locum consultant was scheduled to start with the trust on 26 March 2020.

Inadequate

Urgent and emergency services

- The trust did not have a Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings.
- The trust did not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At RSH consultants worked in the ED Monday to Friday between 8:00am and 8:00pm and 9:00am and 4:00pm at weekends. On call consultant cover was provided at all other times.
- The trust required 32 middle grade doctors to support the emergency care departments across both hospitals. At the time of the inspection, the trust had 14 fully competent middle grade doctors and an additional ten who were supernumerary. The trust anticipated that by June 2020, there would 18 fully competent middle-grades, with an additional twenty supernumerary doctors, totalling 38. These projections were based on successful overseas recruitment campaigns. Overseas recruits had been supported with relocating to the UK including support in sourcing accommodation, English language development courses and support from the consultant body. Each recruit was to be allocated a named consultant responsible for induction, clinical development and pastoral care.
- There were 28 junior doctors working across the two emergency departments. The trust projected that, to facilitate an increase in activity to 130,000 attendances annually, 36 junior doctors were required to safely staff the emergency departments. It was reported a business case was in the process of being finalised to secure the required increase in junior doctors.

Are urgent and emergency services caring?

Inadequate

Compassionate care

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

- We had previously reported that patients in the ED were not consistently supported to receive their care and treatment in a dignified manner. Due to bed capacity challenges at the trust the ED was routinely very busy with patients regularly being nursed on trolley's in corridors. This remained the case at this inspection where 16 patients were nursed in the corridor of period of up to 24 hours during the inspection on 17 February 2020. Patients and visitors were free to walk around the ED as all areas were freely accessible which meant patients on trolleys in corridors were very visible. This included patients who appeared dishevelled and patients who had to lie flat and still in receipt of full spinal immobilisation. Again, these were areas which had previously been highlighted to the trust following previous inspections. We also noted one frail elderly patient who had sustained significant facial injuries following a fall being nursed in a side room. The room remained poorly lit and the door left opened for extended periods of time. Not only did this promote a negative atmosphere within the room, but the patient also reported increasing levels of anxiety because they were disorientated to the time of day. The patient also reported feelings of embarrassment because people walking past their room could see the patient in a dishevelled state and with visible injuries.
- Private areas were not always available, and we saw that patients who received care in corridors were not offered the use of privacy screens when interventions such as taking bloods was completed.
- Staff did not always promote patients' rights to privacy. The ED booking in window was located adjacent to the streaming window so conversations from both windows could be overheard by patients and people visiting the ED. This included patients having to disclose sensitive personal information to the streaming nurse such as their presenting complaint. The privacy and dignity of patients had not been considered by staff despite this having been an area of concern previously raised by the Commission following previous inspections.
- Patients reported nursing staff were kind but clearly rushed and extremely busy. This included one patient

who had been moved to the corridor. Despite being in considerable discomfort through the need to use the toilet, nursing staff handed the patient a urine bottle. There was no consideration to the patient's privacy, with nursing staff expecting the patient to urinate in to the bottle whilst in the corridor with other patients present. Due to the patient's discomfort, they were observed attempting to try to go the toilet. We raised this with the nurse responsible who reported the patient had been moved to the corridor for closer observation; this was despite the patient having been discharged and was waiting for transport home. We requested the nurse found the patient a more suitably private area in order their privacy and dignity was protected.

- We also noted one vulnerable adult with learning disabilities. We initially found the patient having been incontinent of urine. The patient was unable to call for help because whilst their call bell was within reach, it had been disconnected from the wall socket. Despite having been in the department for almost 24 hours, the patient remained in soiled clothes for the duration of their stay. Further, although the patient was being nursed on a hospital bed, the patient continued to wear their shoes. No efforts had been made by staff to make the patient more comfortable, or to change the patient in to clean clothes or a hospital gown for example.

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

(for example, to feedback?)

Inadequate

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

- The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust executive reported the system as being on OPEL two at the time of the inspection. National criteria define OPEL two as "Four-hour access target being at risk of compromise; the local health and social care system is starting to show signs of pressure. The local accident and emergency delivery board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation". Further examples of OPEL two within the national framework are described as "Anticipated pressure in facilitating ambulance handovers; insufficient discharges to create capacity for the expected elective and emergency activity; opening of escalation beds likely; infection control issues emerging; lack of beds across the trust; ED patients with Decision to admit and no action plan". OPEL three is described as "Four-hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".

- There was a general lack of awareness or understanding of the OPEL tool among local clinical leaders. The senior nurse reported they completed regular department risk safety assessments in the department; we observed the assessment being completed at approximately 12:30. The assessment included the number of patients in the department and their locations. The tool was very generic and provided an indicative risk score of amber. This was despite there being 16 patients on the corridor and the resuscitation area being full. There were nine patients in the department with decisions to be admitted but no hospital capacity to move them to inpatient beds. Both the senior nurse and senior doctor in charge felt the department was more aligned to a black status with patient safety compromised due to limited space in the department. The tool had been sourced from another NHS organisation and local leaders were not aware whether the tool had been adapted to ensure it met the needs of the ED at Royal Shrewsbury Hospital, which may have explained the difference in reported acuity and the perceived acuity

among the leadership team. This mis-match between the reported and actual acuity had the potential to introduced inherent risks and false assurance as the information was considered at the operational site meetings.

- An escalation process was in place to enable ED staff to monitor and escalate access and flow problems within the ED. However, staff told us this tool was not always used in line with local guidance due to capacity issues and other pressures within the department. This meant acute changes in access and flow may not always be escalated in a prompt and effective manner. Further, local leaders did not feel the escalation protocol led to any noticeable improvement in terms of resolving patient flow in the department. Executive visibility in the ED was reported to be poor. During the inspection the Director of Nursing was undertaking one of her visits to the Emergency department, she introduced herself to the lead CQC inspector at the time and invited them to contact her at any time should the need arise, or if they needed. We observed no further presence from any of the executive team thereafter.

Median time from arrival to treatment (all patients)

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard and performed worse than the England average over the 12-month period from August 2018 to July 2019. The percentage of patients who were seen and treated by a senior clinical decision maker within 60 minutes from arrival between 23 December 2019 and 2 February 2020 was reported as 23.8%. This was significantly worse than the England average between the same period.
- The average time to treatment was reported as 111 minutes for November 2019. This had increased from 94 minutes when compared to November 2018.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

- In December 2019, a total of 348 patients waited between more than 12 hours from the decision to be admitted being made, to the patient being transferred to a bed, compared to one patient in December 2018.
- Patients could not always access inpatient care from the ED in a timely manner, which meant this patient cohort stayed in the ED for longer than they should have. The trust did not consistently record and monitor the numbers of patients in receipt of corridor care.

Percentage of patients admitted, discharged or transferred within four hours from arrival

- The Department of Health and social care standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From September 2018 to August 2019 the trust consistently failed to meet the standard, and consistently performed worse than the England average.
- The percentage of patients who were admitted, discharged or transferred within four hours from arrival between 23 December 2019 and 2 February 2020 was 70% (includes type 1, type 2 and type 3 cases) (6-week average). Trust wide, for the duration of December 2019, performance against this metric (for all attendance types) was reported as 60.5% which was worse than the data reported for December 2018 (65.5%)
- The percentage of patients who met the “Majors” criteria who spent less than four hours in the emergency department in December 2019 was 52.5%. This was worse than the trusts previous performance for December 2018 which was reported as 58.4%.
- In 2018/2019, NHS Improvement set an initiative in which it was expected all acute NHS trusts in England with a type one emergency department would have an established acute frailty service, providing at least 70 hours of cover each week (NHS Improvement: Same-day acute frailty services). A significant proportion of the patients present in the ED during the inspection were aged over 65 years. Staff reported this was representative of the local demographic and was consistent with the referral and attendance patterns seen in the ED. Despite there being significant numbers of frail elderly patients in the department on a regular basis, and considering the poor departmental flow, resulting in patients remaining in the ED for extended periods of time, the trust had been very slow to implement a robust and well-staffed frailty in reach service. During the inspection we met with a frailty care consultant who was providing in-reach services to the ED and clinical decision unit. The consultant worked in

silo and did not have dedicated access to a wider team as mandated by NHS Improvement. Although there was adhoc access to physiotherapists and occupational therapists, the team did not work collectively to provide a timely multi-disciplinary assessment for frail patients, thus reducing the opportunities for patients to avoid admission. This is in no way a criticism of the local clinical team who were working hard to assess patients but was symptomatic of a wider lack of traction to instigate evidence-based care models mandated by NHS Improvement/NHS England.

Are urgent and emergency services well-led?

Inadequate

Leadership

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

- Despite the Care Quality Commission having inspected and reported against the full key lines of enquiry, as set out in published standards, which detailed the necessary areas for improvement, there remained a significant and profound lack of progress to address longstanding concerns within the department, and wider emergency care pathway. Local leaders did not recognise the serious shortfalls in the quality of care provided in their emergency department. There was a lack of situational awareness, further hampered by poor governance and risk management processes.
- Despite their being a visible presence of leaders in the department, there was a generalised acceptance and blindness to the substandard level of care, provided to frail patients. This included a general acceptance of nursing high risk patients on trolleys for extended periods of time. Nursing staff of all grades considered that due to the design of the mattresses, frail, high risk patients could remain on assessment trolleys for periods of up to 22 hours without there being any tissue damage. This contradicted national best practice guidance which requires that alongside mechanical interventions such as the use of pressure relieving devices, patients at risk of skin damage should also be regularly repositioned and that records of care are maintained to support this. These interventions were absent during the inspection and had not been challenged by senior clinical leaders. Further, nursing staff had not considered the wider implications of patients being nursed for extended periods on trolleys; this included the generalised discomfort associated with the narrow nature of the trolley as an example.
- The local leadership team reported that shortfalls in the consultant workforce had contributed to a lack of change of culture in the department. Further, workforce challenges meant there was limited ability to change governance processes in order there was enough reporting of issues to effect systemwide change.
- Staff reported a sense of isolation and exclusion from the executive team who were described as being “dismissive” of the challenges faced in the emergency department. The lack of robust safety metrics and elements of false assurance perhaps contributed to the perceived lack of seriousness or impact faced by the emergency team and associated care provided.
- The long-standing clinical director was absent on a period of extended leave resulting in another consultant acting-up in to the role. The role of clinical director was being advertised internally, for which we were told there were two existing members of staff who were interested in applying. However, what was apparent through the inspection was a noticeable lack of engagement between the consultant parties across the two emergency departments. There was an element of stubborn behaviour displayed by individual members of the team which added to the lack of progress made across the emergency departments. Staff reported concerns that in the event of an internal appointment being made, there would continue to be a lack of progress on one site over another due to a perceived lack of engagement from consultants at the ED for which they did not work at.
- The nursing leadership team advocated for cross site working with some members of the team undertaking rotational posts across the two emergency departments to help better understand the variations in the quality of services. Six-month rotation programmes had been established for the band seven cohort. These individuals

spoke candidly about the variations with the team at Princess Royal Hospital where staff considered the team there to be more forward-thinking, innovative and demonstrating a wanting to change the status quo.

- Operational nursing leadership at a local level was poor. There was a lack of escalation to more senior trust executive team members where there had been identified and continuing omissions in care. Nursing staff were not acting as advocates for patients as mandated by the Nursing and Midwifery Council Code of Practice which states that all registrants must "Put the interests of people using or needing nursing of midwifery care first… make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to". Nursing and medical staff were not consistently reporting incidents to help improve care and to learn from when things had gone wrong. There was a general culture of the unacceptable becoming normal. We noted multiple occasions where by frail elderly patients were being nursed on assessment trolleys with both the head and feet of the trolley tilted, thus acting as a subtle form of restraint. This was due to patients not being able to easily move or re-position themselves. In addition, extended waits on assessment trolleys, omissions in administering routine medicines, poor compliance with sepsis care bundles and a failure to meet the individual needs of patients were all suggestive of institutional failings.

Vision and strategy for this service

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

- There was no specific vision and strategy specifically dedicated to urgent and emergency care services at the trust. Staff spoke of a departmental philosophy which was orientated towards placing the patient at the centre of the service. However, our findings of this inspection, married with previous inspection findings suggested there was little commitment to the departmental philosophy.
- The trust reported the emergency divisional care group continued to work with system-wide partners including representatives from the Emergency Care Intensive Support Team (ECIST) and NHS Improvement to develop a clear vision and strategy for both the intermediate and long term.
- Departmental leaders spoke of addressing longstanding workforce challenges, as well as having a department which was fit for purpose as the two most pressing concerns which were impacting on the overall quality of the service. Whilst the trust had introduced same day emergency care models for ambulatory patients, as well as establishing an acute medical assessment unit, the service operated a very traditional emergency care model. Frailty pathways had not been fully considered despite there being a national mandate. A lack of capacity for the local team to take time away from clinical duties to focus on wider system improvement plans had been given as the reasons for a lack of robust vision or strategy. Changes and interim appointments to the executive team were also cited as an obstacle to the change agenda.

Governance, risk management and quality measurement

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

- Departmental governance and risk management strategies were ineffective and were not sufficiently resourced to ensure local leaders were aware of, and therefore assured by the quality of services provided. An on-going commitment to undertake regulatory imposed evidence returns, a lack of substantive workforce and a lack of capability within the local team were all citied as contributory factors, which further hampered the development of robust governance processes.
- Local leaders were not fully sighted on the risks associated with the department. There was a reactive attitude to risk management, likely because of there being insufficient dedicated time afforded to the right people with the right skills to undertake robust reviews of governance and quality metrics within the department.
- There was a lack of capacity for the local team to undertake a fresh perspective of the overall quality of care being provided. Some staff had only ever worked at Royal Shrewsbury Hospital and so lacked the insight in to how emergency care and associated care models had

progressed over time. Rotational programmes were reported as being well received by senior nurses as it had afforded them an insight in to another emergency department.

- Although cross-site governance meetings took place monthly, there was limited evidence of change because of these meetings. Some referred to the governance meeting as being a "Tick-box exercise" which "Afforded no real change". Incidents, complaints and regulatory conditions were considered as part of the governance process however, in reality, there remained little change to practice. Serious incidents had been discussed however actions identified were often lack-lustre and insufficient to drive improvements. This included a serious incident in December 2019 when a patient's presenting complaint was not effectively managed. Routine physical observations had not been carried out on the patient in the lead-up to their cardiac arrest. Our review of NEWS2 charts continued to show sporadic compliance with the NEWS2 frequency rules. There was limited evidence in medical and nursing notes of when patients had been escalated in response to an increase in NEWS2 scores. Further, we noted one example where there had been evidence of nursing staff escalating their concerns to the medical registrar on three occasions however there had been no response. The patient was subsequently transferred to the coronary care unit for on-going management instead of waiting for the medical registrar to review the patient in the ED. These were all examples of where there had been a lack of robust governance processes to underpin changes to practice across the emergency department.
- There had been a lack of progress to upskill nursing staff to ensure they were competent to manage children and young people. One member of nursing staff reported there was no requirement for them to be upskilled as they considered children to simply be "Small adults". Infants, children and young people have different physiological, emotional and psychological stages of development and therefore health professionals require extensive experience to safely manage this cohort of patients. We considered the statement of the nurse to be ill-considered and was suggestive of a standard attitude towards the management or infants, children and young people.
- Senior leaders in the department had little awareness of the risks associated with the emergency care service. There was limited insight in to the risks which were captured on the departmental risk register. Senior leaders afforded differing views as to the risks of the department. Whilst medical and nursing staffing were referenced and indeed included as departmental risks, there was limited insight in to the lack of children's nurses. There was limited insight from local leaders in to how nursing establishments had been calculated, which meant little assurance could be taken from the ratio of nurses deployed each shift versus the needs of patients accessing the service. The trust executive team however reported that staffing establishments had been calculated with the support of ECIST, using their recognised staffing model. This assessment was submitted to the public board in May 2019 and included a rationale for the staffing numbers and details of the model used and how the establishment was reached.
- Others described consultant recruitment, the clinical decision unit not being fit for purpose, emergency care exit blocks (including a need to increase the number of nurses deployed to meet the needs of patients as well as an increase in demand), a focus on improving performance against constitutional standards and a requirement for speciality teams to accept responsibility for their patients, were all considered as risks. The wider aspect of quality of care within the department; compliance with trust protocols and practices and at a more basic level, the delivery of fundamental care standards was not seen as risks associated with the ED.

Culture within the service

Staff did not always feel respected, supported and valued.

- We observed some hostile behaviour from one senior manager towards a member of the local ambulance trust who was operating as the Hospital Ambulance Liaison Officer (HALO). The HALO reported they had been "Told off" twice already during their shift for occupying a space at a desk during a period when there were no ambulances waiting to be offloaded. Whilst the HALO reported being resilient, we considered the trust representative was not abiding by the trust values and behaviours, nor were they treating the individual with respect.
  - Staff reported low morale across the department. Two staff spoke candidly about seeking new job opportunities outside of the trust. Their motivations included a perceived lack of progress to improve the

existing nursing establishment; concerns over the quality of care provided; a lack of time to spend with patients, meeting their needs and providing holistic care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
Action the hospital MUST take to improve

Ensure that staff comply with nationally recognised infection control standards. Regulation 12(1)(2)(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients requiring time critical medicines are clinically assessed and such medicines are prescribed and administered in a timely way. Regulation 12(1)(2)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure the privacy and dignity of patients is protected at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Ensure the privacy and dignity of patients is protected at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure that staff comply with nationally recognised infection control standards. Regulation 12(1)(2)(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care Section 29A Health and Social Care Act 2008

The Princess Royal Hospital

Quality Report

Apley Castle
Apley
Telford
TF1 6TF
Tel: 01952 641 222
Website: www.sath.nhs.uk

Date of inspection visit: 18 February 2020
Date of publication: 08/04/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an unannounced focused inspection of the emergency department at Princess Royal Hospital on 18 February 2020, in response to concerning information we had received in relation to care of patients in this department.

We did not inspect any other core service or wards at this hospital, however we did visit the admissions areas to discuss patient flow from the emergency department. We also undertook an unannounced inspection of the emergency department at Royal Shrewsbury Hospital on 17 February 2020 which has been reported separately.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry however we have rated this service in accordance with our enforcement policy.

This was a focused inspection to review concerns relating to the emergency department. It took place between 10am and 4pm on Tuesday 18 February 2020.

We found:

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

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

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

Leaders in the ED did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

Staff did not always feel respected, supported and valued by the senior executive team.

Importantly, the trust must:

Action the hospital MUST take to improve

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable.

Summary of findings

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children.

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales.

Ensure care records are always readily available.

Ensure patients can access care and treatment in a timely way.

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway.

Ensure patients are treated with dignity and their privacy is always protected .

Ensure patients are managed in an environment which is fit for purpose.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to The Princess Royal Hospital

We carried out an unannounced focused inspection of the emergency department at Princess Royal Hospital in response to concerning information we had received in relation to care of patients in this department.

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

We previously inspected the emergency department at Princess Royal Hospital in November 2019. We rated it as inadequate overall. Following this inspection, we initially considered using our urgent enforcement powers due to significant concerns we had over the health and safety of patients in the department. In accordance with guidance issued by the National Quality Board (NQB) and in response to our concerns, system wide risk summits were held on 13 December 2019, 21 January 2020 and 25 February 2020. Risk summits provide a mechanism for key stakeholders involved in the system-wide delivery of health and/or social care to come together to share and review information when a serious concern about the quality of care has been raised. Risk summits enable those organisations to facilitate rapid, collective judgements about the quality of a service and to agree actions needed because of the risks identified.

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

- The trust has 721 acute beds (+9% from June 18), 22 critical care beds (+5% from June 18) and 37 maternity beds (0% change).
- From March 2018 to February 2019, there were 123,851 inpatient admissions (+8% compared to previous year). 9,068 of these were children, approximately 8.6% of all admissions.
- There were 718,882 outpatient attendances (+12% from previous year).
- There were 121,442 accident and emergency department attendances (+9% from previous year).

The trust employs 5,108 WTE staff.

Our inspection team

The team that inspected the service comprised of CQC inspector, a national professional advisor with expertise in urgent and emergency care and an emergency department matron specialist advisor. The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

Inadequate

Urgent and emergency services

Safe	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Information about the service

The emergency department (ED) at Princess Royal Hospital (PRH) provides services 24-hours per day, seven days per week service. The Princess Royal Hospital is the main receiving centre for the acutely unwell child.

The ED at PRH consists of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.
- A main waiting area.
- A children's waiting area for those aged under 13 years.
- One triage room
- A four bedded resuscitation bay.
- Eight majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication
- A four bed 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.
- A clinical decision unit (CDU) that could accommodate up to two patients in separate side rooms plus additional space for patients well enough bot to require a trolley. The CDU operated limited hours, opening at 10.30am and closing at 10pm.
- Four minors' cubicles providing care to patients who presented with minor injuries.
- A fit to sit area
- A children's assessment and treatment cubicle
- A "Pit stop" or rapid assessment area for patients arriving by ambulance, or for those patients who self-presented to the ED who were prioritised by nursing staff.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider and therefore did not form part of this inspection.

During the inspection, we visited the emergency department only. We spoke with 17 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 11 patients and four relatives. During our inspection, we reviewed 33 sets of patient records.

Are urgent and emergency services safe?

Inadequate

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- The Princess Royal hospital ED provides care and initial treatment to patients presenting with injuries or illness in the event of an accident or emergency. The department consisted of a major's unit as well as a minor's injuries unit and a clinical decision unit along with a supported commissioned urgent care centre. The layout of ED comprised of a main waiting area, and a separate waiting area for children under the age of 13 years old. Infants and children were only directed to the separate waiting area once they had been seen by the triage nurse. This resulted in periods of time when children were required to wait alongside adults. Within the main waiting area there were two hatches, one where patients could book in and one to see a streaming nurse who subsequently decided the most appropriate care pathway for the patient, be it minors,

majors, resuscitation or urgent care. A triage room led off the main waiting room. Within the treatment areas there were four 'minors' cubicles for patients with minor injuries or illness and one paediatric cubicle. Eight 'major' cubicles for those patients with major illness or injury and a paediatric treatment room. In addition, there were three 'pit stop' cubicles where rapid assessments were carried out following triage, and two cubicles for fit to sit with a chair and another with a trolley. The resuscitation area comprised a large room with four open bays and one of which was designed for paediatric patients. A clinical decision unit, which had two bedded cubicles and two cubicles for seated patients. The CDU operated Monday to Sunday from 10.30am to 10pm at night.

- The design of the environment did not follow national guidance. For example, national guidance aimed at providing a safe environment for children presenting at an ED was not being followed. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was also not being followed. Children waiting to be seen by the triage nurse were required to wait in the main adult waiting area. During periods of peak activity, nursing staff reported it was not unusual for children to wait up to one hour before being seen by the triage nurse, and then subsequently directed to the separate waiting area. Additionally, nursing staff reported they actively enforced the local policy that the waiting room was only for use for those aged under 13 years of age. This was contrary to national standards which identifies children as anyone under the age of 18. Whilst it is common practice for those aged 16-17 to be given a choice as to where they would wish to wait to be seen or treated, we noted the local age policy was discriminatory to those aged under 16 years of age. Further, those aged 13 to 16 who were required to wait in the main adult waiting room were likely to be in a position whereby they were exposed to other patients who presented with challenging behaviours, or those who were intoxicated or under the influence of illegal substances for example.
- National guidance relating to provision of a safe environment for patients presenting at the ED with acute mental health concerns had improved. At our previous inspection, the trust was in the process of adapting a room which complied with the July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care standards which recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. At the time of our inspection, a new room had recently been completed. The room had two means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observation of patients and lighting was adjustable to allow patients to get rest. However, there were several pieces of furniture in the room which did not meet national standards as they could be used as a missile including a lightweight general waste bin and chairs. Air ventilation shafts were present in the room, suggestive of pipework being present above the false, non-secured ceiling tiles; such pipework and other ancillary equipment posed ligature risks.
- Access to the majors ED from the main waiting area was via secure access. There were elements of the ED which were not as secure, such as via the x-ray department. There was however the ability for ED staff to "Lock-down" the ED as required.
- Because of bed capacity challenges at the trust, patients were regularly and routinely cared for in the ED corridors. Corridors were relatively wide however patients were mainly cared for on assessment trolleys to reduce the risk of corridors becoming too narrow for patients to be transferred, or in the event a major unplanned evacuation was required. However, patients did not always have access to call bells to alert staff in the event they required assistance. Patients located on trolleys and chairs in the corridors did not have access to call bells. We spoke with three patients who were being cared for along the corridor. They reported they relied on waiting for a member of staff to pass by or had to ask a relative or call out for help. This meant there was an inherent risk in that those patients who may feel acutely unwell or who were at risk of rapidly deteriorating, may not be able to call for immediate help.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

- National guidance relating to the initial assessment of patients who presented at the ED was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. A triage and streaming system were in place that aimed to prioritise patients, so they could receive the right care at the right time in the right place. After booking in at reception, patients were redirected to the "Yellow zone" before being called to a second window to speak with the streaming nurse. The streaming nurse asked clinical questions and identified patients who could be seen at the urgent care centre (another service based on site but managed by another provider). They also allocated patients to a triage queue or directed patients straight to resus if they had very urgent care needs. Following concerns identified at previous inspections, we imposed regulatory conditions of the trusts' registration which required them to operate an effective triage process. This was to enable better awareness among staff as to the clinical acuity of patients who self-presented to the department.

- The trust was legally required to submit information on a routine basis detailing how they were meeting these conditions and to explore any potential harm caused to patients who may not have been initially assessed within a timely way. We used this information as a means of gaining assurance that patients were being clinically assessed within an appropriate timeframe. However, we noted during an inspection of the service in November 2019 that there was ambiguity as to the time being recorded on the patient's CAS card, which was used by local leaders to compile the section 31 returns. Staff reported that once a patient had seen the streaming nurse, this time was recorded on the CAS card. However, due to the nature of the mixed streaming/triage process used in the department, the streaming nurse was not able to clinically assess a patient as they had no location to undertake vital sign observations to facilitate an appropriate triage assessment. Whilst those patients who looked extremely unwell could be expediated to majors, or to the resuscitation room, those patients who presented with mild symptoms of chest pain, or had underlying deranged vital signs for example, may not have been so easily detected, especially if a patient was in a clinically compensated state. The body has inherent survival mechanisms which are triggered during periods of critical illness for example. These processes are often only sustainable for short periods of time, and once exhausted, the body succumbs to the symptoms of the underlying illness. This compensatory mechanism can initially mask the actual acuity of a patient and can mislead health professionals if the underlying cause is not quickly identified, resulting in patients rapidly deteriorating. The trust subsequently reported they only monitored the time it took from patients booking in to being streamed, rather than the time from booking in to triage. Trust data showed the average time to streaming between August 2018 and October 2019 was 20.5 minutes. This meant the trust was consistently not meeting the 15-minute triage standard for adults. Additionally, because patients experienced an initial delay in being triaged, the resulting impact was an increasing wait to also be seen by a senior clinical decision maker and a plan of care commenced. On 17 February 2020 we observed there to be limited numbers of patients self-presenting to the emergency department. This meant patients experienced minimal waits between booking in with reception staff and being seen by the streaming nurse. However, despite there being minimal activity on the day of the inspection, there were still periods of time when patients waited more than 15 minutes even to be seen by the streaming nurse, despite there being no other patients in the streaming queue. This raised a query over the productivity of the streaming nurse as there was no apparent reason for patients waiting extended periods of time between booking in and being streamed.

- During the inspection we observed the streaming and triage process and whilst there were minimal waits for

patients to be seen by the streaming nurse, patients referred to be seen by the triage nurse often waited periods of 20 minutes of more before they had a set of observations were completed; this was despite the waiting room being relatively quiet on the day of the inspection. However, nursing staff reported that during peak times, it was not uncommon for patients to wait up to an hour between being streamed and being seen by the triage nurse. This suggested that when busy, patients could expect to wait extended periods of time before nursing staff could ascertain a baseline for the patient, to aid the developing an appropriate triage protocol.

- We had previously raised concerns that patients arriving by ambulance were often delayed in being clinically assessed and handed over. This meant there was a risk acutely unwell patients may not have received time critical care and treatment. To address ongoing challenges, the trust had previously created a clinical pit-stop area as part of a rapid improvement project. This area was used to allow for patients arriving by ambulance (and on occasion, patients who self-presented who appeared extremely sick) to be rapidly assessed by a senior nurse. During this inspection, we observed this process working well. Patients were received, in general, in a timely way by the pitstop nurse. Clinical interventions including electrocardiograms (ECGs), blood tests and other assessments were carried out quickly and routinely within 15 minutes. We observed instances when the nurse was sufficiently concerned about the condition of a patient and subsequently escalated the patient to medical staff who then carried out timely assessments of patients.
- In the period leading up to and during Christmas 2019, the hospital was experiencing high numbers of ambulances which were delayed by more than 60 minutes from arrival to handing over patients. Data shows peaks and troughs in the number of ambulances delayed during this time ranging from five to 28 ambulances each day. There was then sustained improvement between 15 January 2020 and 29 January when fewer than five ambulances were delayed daily. Peaks in activity were then noted thereafter with up to 15 ambulances delayed by more than 60 mins, daily. During the inspection, ambulances were offloaded, and patients handed over in a timely way. However, staff reported that there were occasions when ambulances were required to cohort their patients, or experienced delays in handing their patients over. We asked staff to describe the process for providing clinical oversight and to outline the assessment pathways for patients who were cohorted and who could not be handed over. We were told there was currently no standard operating procedure for the oversight of the ambulance queue. Nursing and medical staff reported they would not routinely review those patients in the ambulance queue unless a paramedic or technician were concerned about the patient and therefore escalated their concerns to the nurse in charge. This presented a significant clinical risk and was contrary to national guidance issued by NHS Improvement in 2017 ("Addressing ambulance handover delays: actions for local accident and emergency delivery boards"). This mandates that "The patient is the responsibility of the ED from the moment the ambulance arrives outside the ED, regardless of the exact location of the ambulance".
- Although nursing staff had access to nationally recognised risk assessment tools including the national early warning scoring system (NEWS2), Waterlow skin risk assessment tools and sepsis six care bundles, compliance with the applications of these tools was varied. The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were designed to help clinical staff to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Whilst staff were commencing sepsis screening tools for patients, they did not consistently follow trust protocols. For example, staff routinely identified patients as being at low risk of sepsis despite patients having recorded early warning scores of two in single parameters. The trust policy requires staff to proceed with the flow chart where patients have a single parameter scoring two or more.
- There was sporadic use of the NEWS2 tool. Where patients had met the criteria for hourly monitoring, as part of the NEWS2 escalation and management protocol, there was sporadic compliance noted from the comprehensive review of the clinical notes we considered during the inspection.
- Patients identified as being at high risk of pressure damage through Waterlow skin assessments, remained

on trolleys for extended periods of time with no active mitigations. This included one elderly patient who had been recognised as being at very high risk of skin damage remaining on an assessment trolley for 15 hours. Nursing documentation was poor and did not describe the routine skin care provided to this patient. This was contrary to national guidance which states: The National Institute for Health and Care Excellence, Clinical Guideline 179: Pressure ulcers: prevention and management recommend that patients identified as being at "High risk" should be supported to be repositioned every four hours and that the frequency of repositioning should be recorded.

- A second patient had also been identified as being at very high risk of skin damage, with a Waterlow score of 21. Again, this patient remained on an assessment trolley with no additional protective measures in place for a period of 17 hours. There was no routine documentation to demonstrate how nursing staff had met the needs of the patient through regular repositioning and skin care being provided. A third patient was in significant back pain and despite having complained about their discomfort whilst awaiting transfer to another service, there had been no efforts made to transfer the patient to a more comfortable bed. The patient had been in the department for more than 12 hours.
- Care records were often incomplete and, in some cases, missing altogether. This included one patient who had initially presented to the department in significant abdominal pain. Despite the patient waiting for approximately one hour and fifty minutes between being triaged and being called to be seen by a doctor no analgesia was offered to the patient. We opted to case track the patient through their journey however when we asked to see the notes of the patient in the afternoon nursing staff could not locate them and could not recall the outcome for the patient. Of the ten sets of paediatric notes reviewed, three did not contain any written record of any clinical assessment or treatment plan by doctors. Nursing staff reported that medical staff would often use a paediatric proforma but that these should be stored with the clinical notes; no such proforma was found despite the children having received clinical interventions such as medicines being prescribed for the management of asthma as an example. We raised this with nursing staff who reported it was not uncommon for CAS cards to be missing. This was further supported by reception staff who were responsible for the CAS cards once patients had been discharged. They reported that doctors may take the CAS cards, or they may have accidentally been sent to the ward. This meant that should a patient reattend, there was no clinical written record available to clinical staff detailing previous treatments or clinical interventions or treatment plans. This introduced a level of inherent risk to patients for which there was currently no robust action plan to resolve in the interim until a full electronic patient record system was introduced in to the ED in May 2020.
- Local policies required patients who presented with chest pain to have an electrocardiogram within a defined period. We reviewed some 34 sets of notes during the inspection and found that on six occasions when an ECG was clinically indicated, patients waited for periods of one hour or more before receiving their first ECG. This meant there was a risk to patients of not receiving time critical treatment in the event they presented with acute coronary syndromes or other time critical conditions.

Nursing staffing

The service did not have enough permanent nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. However, staffing gaps were filled with temporary bank and agency staff.

- The service did not have had enough permanent nursing staff to keep patients safe. There was a very high reliance on temporary bank and agency staff. This was observed to be the case during the inspection. We spoke with four agency nurses, some of whom had been allocated a set block of shifts to support the ED. Each agency nurse reported they were familiar with the department. They could describe the actions they would take in the event a patient deteriorated, including the use of the NEWS2 system, as well as being able to identify the location of resuscitation trolleys. Although agency staff did not have access to electronic systems, therefore hindering their ability to view x-ray reports for example, each agency nurse could describe who they would liaise with to gain access.

- Local leaders reported they had completed a baseline staffing assessment to determine the numbers of nursing and health support workers required to safely manage the department. It was reported this assessment was carried out using the Royal College of Emergency Medicine Baseline Emergency Staffing Tool (BEST). Because of the assessment, 16 nurses were deployed for each day shift. Nursing staff considered this to be enough nurses to meet the needs of patients when the department was at capacity. There were concerns raised that 16 nurses were not enough however when the department was above capacity. It was reported that on 17 February (the day prior to our inspection), clinical need required there to be five patients in the resuscitation area; nursing staff reported that this placed additional burden on the nurse assigned to the resuscitation room, although they acknowledged an additional member of staff had been allocated to support them.
- During the inspection we observed the clinical decision unit to be staffed at all times.
- The trust reported they required 14 band seven nurses, 63 band six, 53 band five and two practice development nurses to safely staff both emergency departments. At the time of the inspection, there were four vacant band seven posts (29% vacancy rate); 23 band six posts (36.5% vacancy rate), 39 band five posts (73.5% vacancy rate) and both practice development roles were also vacant (100% vacancy rate). The trust reported adverts for the band seven roles had attracted 11 applications with ten individuals shortlisted for interview. 12 applications had been received for the band six roles with nine individuals shortlisted for interview. Eight individuals were shortlisted for interview on 27 February 2020.
- The trust reported they were undertaking an extensive overseas nurse recruitment campaign directed at closing the high band five vacancy gap. Six nurses had arrived in to the UK on 5 December 2019 who were shortly followed with an additional 48 nurses. Six nurses had undertaken their observational scenario clinical examinations to enable them relevant registration with the Nursing and Midwifery Council, and therefore the legal ability to work in the UK as a nurse. A further nine nurses were scheduled to undertake the OSCEs on 14 February 2020. The trust anticipated that by May 2020, 106 overseas nurses would have arrived. A further overseas pipeline of OSCE ready nurses had recently been interviewed from which 28 had been identified as being suitably competent to work in the emergency departments across the trust.
- As at December 2019, the trust reported that of the 9,958 total nursing care hours required to provide care and treatment, 519 hours had remained unfilled. Despite the use of temporary staffing, this meant the department remained understaffed by 3.1 whole time equivalent nurses through December 2019.
- In total, 52% of care hours were covered through temporary staffing arrangements, 5% of care hours were unfilled, and 43% were covered through substantive staffing arrangements. 26% of care hours in December were covered through block-booked agency staff; 18% through adhoc agency and 8% supported through bank staff cover.
- The trust did not have enough children's nurses to meet the June 2018 Royal College of Paediatrics and Child Health guidance, Facing the Future: Standards for children in emergency care settings. There were not enough children's nurses employed by the trust to ensure two children's nurses were available on each shift. An ongoing recruitment programme was in place to try and address this. The Care Quality Commission recognises the challenges of recruiting enough numbers of qualified and competent children's nurses to provide continuous emergency care services which meet the RCPCH standards. This is also recognised as a challenge within the standards themselves. However, providers must ensure they recruit and deploy enough numbers of staff with the right skills, training and competency to provide safe and effective care. The standards state that providers should ensure that where there are recruitment challenges, it is essential that a flexible workforce is developed whereby staff are competent and safe to care for infants, children and adults and that this should include emergency care skills.
- We asked local leaders whether adult nursing staff had received any additional training or completed recognised competency frameworks to help them to care for infants, children and young people. We were informed that no such competency framework existed at the trust. We raised this as a significant area of concern with the trust executive team. They subsequently reported they were acting to ensure there

were enough numbers of nursing staff each shift to meet the needs of children. We continue to monitor this closely with the trust and system partners and will take appropriate action if we identify further concerns.

Medical staffing

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

- The service did not have had enough permanent medical staff to keep patients safe. There was a very high reliance on agency and locum staff. The trust was commissioned to provide type one and type two emergency care services across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed six whole time equivalent consultants against an anticipated establishment of 20. However, because of long term sickness and maternity leave, only four consultants were available across the two emergency departments to provide consultant presence.
- There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies).
- An interview had been scheduled for 24 February 2020 for one candidate for the role of substantive consultant.
- The department was supported by four further locum ED consultants who had been booked until at least March 2020; a further one locum consultant was scheduled to start with the trust on 26 March 2020.
- The trust did not have a Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings.
- The trust did not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At Princess Royal Hospital, consultants worked in the ED Monday to Friday between 8:00am and 10:00pm and 9:00am and 3:00pm at weekends. On call consultant cover was provided at all other times.
- The trust required 32 middle grade doctors to support the emergency care departments across both hospitals. At the time of the inspection, the trust had 14 fully competent middle grade doctors and an additional ten who were supernumerary. The trust anticipated that by June 2020, there would 18 fully competent middle-grades, with an additional twenty supernumerary doctors, totalling 38. These projections were based on successful overseas recruitment campaigns. Overseas recruits had been supported with relocating to the UK including support in sourcing accommodation, English language development courses and support from the consultant body. Each recruit was to be allocated a named consultant responsible for induction, clinical development and pastoral care.
- There were 28 junior doctors working across the two emergency departments. The trust projected that, to facilitate an increase in activity to 130,000 attendances annually, 36 junior doctors were required to safely staff the emergency departments. It was reported a business case was in the process of being finalised to secure the required increase in junior doctors.
- Senior doctors reported significant concerns that it was difficult to co-ordinate the department safely and effectively whilst also undertaking other activities such as clinical governance responsibilities, mortality and morbidity reviews and participate in audit programmes.

Inadequate

Urgent and emergency services

Are urgent and emergency services caring?

Requires improvement

Compassionate care

The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

- Due to the congestion within the department, there were many occasions when patients were being nursed in corridors. In most cases, patients were covered with blankets and their personal needs were reported to be met. Staff told us that patients were transferred to a bay in the clinical decision unit (CDU) within the department if personal care was required for immobile patients. There were occasions during the inspection when clinical interventions such as phlebotomy (blood taking) was undertaken in the corridor due to the CDU being full.
- Staff did not always respect patient's privacy and dignity while they were in the department. Patients dignity was not always observed within the waiting room. Conversations between the streaming nurse and patients could be easily overheard by other patients, thus infringing on patient confidentiality. This had previously been raised as an area of concern however it was felt by nursing staff that the practice had been normalised. Nursing staff were keen to change the streaming process however they did not feel they had the autonomy to do so.
- Senior staff reported the CDU closed at 10pm each night and reopened at 10.30 the following morning. On our arrival we noted three patients, including two frail elderly patients, had been nursed on assessment trolleys in the corridor all night despite there being side rooms available in the CDU. We raised this with senior leaders who had not considered the individual needs of patients and there was a significant resistance to accommodating patients overnight in the CDU overnight, with the standard operating model in the ED being one in which patients would be managed on the corridor. This was not conducive to the privacy and dignity of patients, nor was it a positive experience for patients.

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

(for example, to feedback?)

Inadequate

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

- The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care. The trust executive reported the system as being on OPEL two at the time of the inspection. National criteria define OPEL two as "Four-hour access target being at risk of compromise; the local health and social care system is starting to show signs of pressure. The local accident and emergency delivery board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation". Further examples of OPEL two within the national framework are described as "Anticipated pressure in facilitating ambulance handovers; insufficient discharges to create capacity for the expected elective and emergency activity; opening of escalation beds likely; infection control issues emerging; lack of beds across the trust; ED patients with Decision

to admit and no action plan". OPEL three is described as "Four-hour access target significantly compromised; significant numbers of handover delays; patient flow significantly compromised".

- An escalation process was in place to enable ED staff to monitor and escalate access and flow problems within the ED. However, staff told us this tool was not always used in line with local guidance due to capacity issues and other pressures within the department. This meant acute changes in access and flow may not always be escalated in a prompt and effective manner. Further, local leaders did not feel the escalation protocol led to any noticeable improvement in terms of resolving patient flow in the department. Executive visibility in the ED was reported to be poor.

Median time from arrival to treatment (all patients)

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust consistently failed to meet the standard and performed worse than the England average over the 12-month period from August 2018 to July 2019. The percentage of patients who were seen and treated by a senior clinical decision maker within 60 minutes from arrival between 23 December 2019 and 2 February 2020 was reported as 24.2%. This was significantly worse than the England average between the same time period.
- The average time to treatment was reported as 111 minutes for November 2019. This had increased from 94 minutes when compared to November 2018.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

- In December 2019, a total of 348 patients waited between more than 12 hours from the decision to be admitted being made, to the patient being transferred to a bed, compared to one patient in December 2018.
- Patients could not always access inpatient care from the ED in a timely manner, which meant this patient cohort stayed in the ED for longer than they should have. The trust did not consistently record and monitor the numbers of patients in receipt of corridor care.

Percentage of patients admitted, discharged or transferred within four hours from arrival

- The Department of Health and Social Care standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From September 2018 to August 2019 the trust consistently failed to meet the standard, and consistently performed worse than the England average.
- The percentage of patients who were admitted, discharged or transferred within four hours from arrival between 23 December 2019 and 2 February 2020 was 70% (includes type 1, type 2 and type 3 cases) (6 week average). Trust wide, for the duration of December 2019, performance against this metric (for all attendance types) was reported as 68.1% which was worse than the data reported for December 2018 (65.5%)
- The percentage of patients who met the “Majors” criteria who spent less than four hours in the emergency department in December 2019 was 57.9%. This was worse than the trusts previous performance for December 2018 which was reported as 58.4%.

Are urgent and emergency services well-led?

Inadequate

Leadership

Leaders did not have the skills and abilities to run the service in a safe and effective manner. Leaders did not understand and manage the priorities and issues the service faced. Senior leaders were not always visible and approachable in the service for patients and staff.

- Despite the Care Quality Commission having previously inspected and reported against the full key lines of enquiry, as set out in published standards, which detailed the necessary areas for improvement, there remained a significant and profound lack of progress to address longstanding concerns within the department, and wider emergency care pathway. Local leaders did not recognise the serious shortfalls in the quality of care provided in their emergency department. There was a lack of situational awareness, further hampered by poor governance and risk management processes.

- Despite their being a visible presence of leaders in the department, there was a generalised acceptance and blindness to the substandard level of care provided to frail patients. This included a general acceptance of nursing high risk patients on trolleys for extended periods of time. Nursing staff of all grades considered that due to the design of the mattresses, frail, high risk patients could remain on assessment trolleys for periods of up to 16 hours without there being any tissue damage. This contradicted national best practice guidance which requires that alongside mechanical interventions such as the use of pressure relieving devices, patients at risk of skin damage should also be regularly repositioned and that records of care are maintained to support this. These interventions were absent during the inspection and had not been challenged by senior clinical leaders. Further, nursing staff had not considered the wider implications of patients being nursed for extended periods on trolleys; this included the generalised discomfort associated with the narrow nature of the trolley as an example.
- The local leadership team reported that shortfalls in the consultant workforce had contributed to a lack of change of culture in the department. Further, workforce challenges meant there was limited ability to change governance processes in order there was enough reporting of issues to effect systemwide change.
- Staff reported a sense of isolation and exclusion from the executive team who were "dismissive" of the challenges faced in the emergency department. The lack of robust safety metrics and elements of false assurance perhaps contributed to the perceived lack of seriousness or impact faced by the emergency team and associated care provided. Anecdotally, we were told that on the 17 February 2020 the department had 108 patients with five patients being managed in the resuscitation room. 15 patients were waiting for extended periods with ambulance crews due to the pit stop area being full. Whilst a senior staff member raised concerns with the executive team, it was reported there was no formal or robust response, other than being informed there was no in-patient capacity in the trust. This left staff feeling demoralised and dismissed despite them having safety concerns.
- The trust operated two major emergency departments which were managed and overseen by a clinical director. At the time of the inspection, the long-standing clinical director was absent on a period of extended leave resulting in another consultant acting-up in to the role. The role of clinical director was being advertised internally, for which we were told there were two existing members of staff who were interested in applying. However, what was apparent through the inspection was the wilful lack of engagement between the consultant parties across the two emergency departments. There was an element of stubborn behaviour displayed by individual members of the team which added to the lack of progress made across the emergency departments. Staff reported concerns that in the event of an internal appointment being made, there would continue to be a lack of progress on one site over another due to a perceived lack of engagement from consultants at the ED for which they did not work at.
- The nursing leadership team advocated for cross site working with some members of the team undertaking rotational posts across the two emergency departments to help better understand the variations in the quality of services. Six-month rotation programmes had been established for the band seven cohort. These individuals spoke candidly about the variations with the team at Princess Royal Hospital where staff considered the team there to be more forward-thinking, innovative and demonstrating a wanting to change the status quo.
- Operational nursing leadership at a local level was poor. There was a lack of escalation to more senior trust executive team members where there had been identified and continuing omissions in care. Nursing staff were not acting as advocates for patients as mandated by the Nursing and Midwifery Council Code of Practice which states that all registrants must "Put the interests of people using or needing nursing of midwifery care first… make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to". Nursing and medical staff were not consistently reporting incidents to help improve care and to learn from when things had gone wrong. In addition, extended waits on assessment trolleys, omissions in administering routine medicines, poor compliance with sepsis care bundles and a failure to meet the individual needs of patients were all suggested of institutional failings.

Inadequate

Urgent and emergency services

Vision and strategy for this service

The service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action. However, senior leaders engaged with stakeholders regarding the planning of future ED services.

- There was no specific vision and strategy specifically dedicated to urgent and emergency care services at the trust. Staff spoke of a departmental philosophy which was orientated towards placing the patient at the centre of the service. However, our findings of this inspection, married with previous inspection findings suggested there was little commitment to the departmental philosophy.
- The trust reported the emergency divisional care group continued to work with system-wide partners including representatives from the Emergency Care Intensive Support Team (ECIST) and NHS Improvement to develop a clear vision and strategy for both the intermediate and long term.
- Departmental leaders spoke of addressing longstanding workforce challenges, as well as having a department which was fit for purpose as the two most pressing concerns which were impacting on the overall quality of the service. Whilst the trust had introduced same day emergency care models for ambulatory patients, as well as establishing an acute medical assessment unit, the service operated a very traditional emergency care model. Frailty pathways had not been fully considered despite there being a national mandate. A lack of capacity for the local team to take time away from clinical duties to focus on wider system improvement plans had been given as the reasons for a lack of robust vision or strategy. Changes and interim appointments to the executive team were also cited as an obstacle to the change agenda.
- Consultants reported feeling disconnected from the executive team in terms of the development of a robust emergency care strategy. The team reported they had not been included in discussions regarding clinical pathways or new models of care.

Governance, risk management and quality measurement

Leaders in the emergency department did not operate effective governance processes throughout the service. The service did not always identify, escalate and mitigate relevant risks and issues.

- Departmental governance and risk management strategies were ineffective and were not sufficiently resourced to ensure local leaders were aware of, and therefore assured by the quality of services provided. An on-going commitment to undertake regulatory imposed evidence returns, a lack of substantive workforce and a lack of capability within the local team were all citied as contributory factors, which further hampered the development of robust governance processes.
- Local leaders were not fully sighted on the risks associated with the department. There was a reactive attitude to risk management, likely because of there being insufficient dedicated time afforded to the right people with the right skills to undertake robust reviews of governance and quality metrics within the department.
- There was a lack of capacity for the local team to undertake a fresh perspective of the overall quality of care being provided. Some staff had only ever worked at Royal Shrewsbury Hospital and so lacked the insight in to how emergency care and associated care models had progressed over time. Rotational programmes were reported as being well received by senior nurses as it had afforded them an insight in to another emergency department.
- Although cross-site governance meetings took place monthly, there was limited evidence of change because of these meetings. Some referred to the governance meeting as being a “tick-box exercise” which “afforded no real change”. Incidents, complaints and regulatory conditions were considered as part of the governance process however, in reality, there remained little change to practice. Serious incidents had been discussed however actions identified were often lack-lustre and insufficient to drive improvements. This included a serious incident in December 2019 when a patient’s presenting complaint was not effectively managed. Routine physical observations had not been carried out on the patient in the lead-up to their cardiac arrest. Our review of NEWS2 charts continued to show sporadic

compliance with the NEWS2 frequency rules. There was limited evidence in medical and nursing notes of when patients had been escalated in response to an increase in NEWS2 scores. Further, we noted one example where there had been evidence of nursing staff escalating their concerns to the medical registrar on three occasions however there had been no response. The patient was subsequently transferred to the coronary care unit for on-going management instead of waiting for the medical registrar to review the patient in the ED. These were all examples of where there had been a lack of robust governance processes to underpin changes to practice across the emergency department.

- There had been a lack of progress to upskill nursing staff to ensure they were competent to manage children and young people.
- Senior leaders in the department had little awareness of the risks associated with the emergency care service. There was limited insight in to the risks which were captured on the departmental risk register. Senior leaders afforded differing views as to the risks of the department. Whilst medical and nursing staffing were referenced and indeed included as departmental risks, there was limited insight in to the lack of children's nurses. There was limited insight from local leaders in to how nursing establishments had been calculated, which meant little assurance could be taken from the ratio of nurses deployed each shift versus the needs of patients accessing the service. The trust executive team however reported that staffing establishments had been calculated with the support of ECIST, using their recognised staffing model. This assessment was submitted to the public board in May 2019 and included a rationale for the staffing numbers and details of the model used and how the establishment was reached.
- Others described consultant recruitment, the clinical decision unit not being fit for purpose, emergency care exit blocks (including a need to increase the number of nurses deployed to meet the needs of patients as well as an increase in demand), a focus on improving performance against constitutional standards and a requirement for speciality teams to accept responsibility for their patients, were all considered as risks. The wider aspect of quality of care within the department; compliance with trust protocols and practices and at a more basic level, the delivery of fundamental care standards was not seen as risks associated with the ED.

Culture within the service

Staff did not always feel respected, supported and valued.

- Staff reported low morale across the department. A feeling of disconnect from the wider trust and executive team were both common themes when speaking with staff about morale. Some senior nursing staff did not feel empowered to make change, in part associated with allegations of bullying from more senior members of staff. However, at a local level, staff reported they worked well as a team. Individuals felt they could rely on other members of the emergency care team, even during periods of high demand. Staff spoke positively about the rapid improvement projects which had taken place, including the introduction of the pit-stop area. Although staff said they were encouraged to report incidents, time constraints were cited as reasons for not always doing so, meaning there was the potential for missed opportunities to learn and enhance patient safety in the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

Ensure care records are always readily available. Regulation 17(1)(2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients privacy and dignity is maintained at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Ensure the privacy and dignity of patients is protected at all times. Regulation 10(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure staff comply with local early warning systems to ensure patients at risk of deterioration are recognised and treated within defined time scales. Regulation 12(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients can access care and treatment in a timely way. Regulation 12(1)(2)(a)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Ensure patients, including those who present with mental health concerns, are managed in an environment which is fit for purpose. Regulation 12(1)(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. Regulation 17(1)(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed . This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. Regulation 18(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care Section 29A Health and Social Care Act 2008

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Organisational Quality Governance Actions

Experience, Quality & Safety Committee

04 June 2020

Agenda Item 3.3

Introduction

This slide pack provides the Experience, Quality & Safety Committee with an overview of progress against quality governance self-assessments undertaken during 2019/20 and identifies the mechanisms for delivery during 2020/21:

- **PTHB Self-assessment against recommendations arising from RCOG/RCM Independent Review into Maternity Services at Cwm Taf University Health Board, undertaken in June 2019**
  - 21 areas assessed – 0 low level assurance, 9 medium level assurance and 12 high level assurance
  - Improvement actions required in respect of the 9 medium level assurance areas relate to: Information analysis and intelligence reporting; Clinical Quality Review Meetings with 15 NHS providers; Concerns management; Risk management; Clinical Audit and Board development
- **PTHB Self-assessment against WG's Quality Governance Arrangements, undertaken in December 2019**
  - 14 areas assessed – 3 low level assurance, 10 medium level assurance and 1 high level assurance
  - Improvement actions required in respect of the 3 low level assurance areas relate to: Clinical Audit; DATIX; and Concerns management.

PTHB Assessment against RCOG/RCM Recommendations arising from A Review of Maternity Services at Cwm Taf Health Board – June 2019

RCOG/RCM Recommendations

Terms of reference from the review & recommendations	Health Board response and level of assurance (High, Medium, Low)		Areas for improvement	Status & Mechanism for Delivery
TOR 1: To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.	**Information** Confidence with local data for Powys midwifery services via IFOR and Rosetta, albeit the Rosetta system requires strengthening. Intelligence gathering regarding commissioned services requires strengthening.	Medium	• Implement the Information Systems Review recommendations (including the assessment of the Rosetta System) • Review approaches to securing information from commissioned services, including maximising CHKS.	CQF Implementation Plan
	Clinical Audit All clinical directorates have an annual audit programme, with midwifery identified as having the more robust approach to clinical audit as identified via Internal Audit. The organisational approach to clinical audit requires improvement in terms of reporting outcomes through the Quality Committee (as identified via an Internal Audit review of Clinical Audit)	Medium	• Implement the recommendations from the Internal Audit review.	CQF Implementation Plan

RCOG/RCM Recommendations

Terms of reference from the review & recommendations	Health Board response and level of assurance (High, Medium, Low)		Areas for improvement	Status & Mechanism for Delivery
TOR 2: Assess the prevalence and effectiveness of a patient safety culture within maternity services including: **The understanding of staff of their roles and responsibilities for delivery of that culture.** **Identifying any concerns that may prevent staff raising patient safety concerns within the Trust.** **Assessing that services are well led and the culture supports learning and improvement following incidents.**	**Risk Management** There is a robust approach to the identification, management and mitigation of risk within midwifery services, to include the appropriate use of DATIX (with a rolling programme of Datix training available) and a Datix tracker via the M Drive. Risk management is an area for organisational development, as identified through a review undertaken by Internal Audit (Limited Assurance rating). The PTHB BAF has undergone a refresh in quarter 1 (2019/20)	Medium	• Risk Intelligence analysis for Commissioned Services • Organisational Risk Management: ownership, reporting, moderation and mitigation • PTHB Board Assurance Framework - full implementation during 19/20	Annual Governance Programme/ CQF Implementation Plan
	Meetings infrastructure A formal review of meetings and meeting attendance has been undertaken within midwifery services with streamlining and reduced duplication. An evaluation demonstrated increased productivity as a direct result. The Senior Clinical Leadership Team has received support from the Medical Director and Director of Nursing to secure a collegiate, collaborative & more strategic approach. The Board has reviewed it's Committee infrastructure to strengthen alignment to the Health & Care Strategy, IMTP & delivery against the BAF	Medium	• Q3 review of the impact of the revised committee infrastructure	Annual Governance Programme

RCOG/RCM Recommendations

Terms of reference from the review & recommendations	Health Board response and level of assurance (High, Medium, Low)		Areas for improvement	Status & Mechanism for Delivery
TOR 3: Review the RCA investigation process, how Sis are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.	**Serious Incident Process** PTHB has a clear process for the reporting and management of Serious Incidents but our compliance to SI closure timescales requires improvement. PTHB undertakes an annual death review process for maternity and children, which has multidisciplinary attendance. Cases are reviewed and lessons identified, which are recorded.	Medium	• Strengthen the organisational approach to the SI closure process and compliance to timescales • Secure Medical input into the annual Death Review process (to include MD and an external Obstetrician)	CQF Implementation Plan
	Learning Culture There is a culture of review, reflect and act within midwifery services and evidence of cascade learning and inter-directorate sharing. Work plans include time for reflection, supervision and case reviews and the service has introduced the concept of 'Feedback Friday' & a monthly Governance Newsletter	Medium	• Strengthen organisational learning. • Introduce the Assistant Director role for Innovation and Improvement	CQF Implementation Plan
	Datix See Risk Management response in '2'	Medium	• Enhance organisational understanding of the DATIX system and it's opportunities	CQF Implementation Plan

RCOG/RCM Recommendations

Terms of reference from the review & recommendations	Health Board response and level of assurance (High, Medium, Low)		Areas for improvement	Status & Mechanism for Delivery
TOR 8: Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.	**Complaints** PTHB has undertaken a review of its PTR Policy and this is due to go to Board for approval in May 2019. The effective and timely management and resolution of concerns is an issue for PTHB, with inadequate compliance to the 30 day turnaround for responses. The quality of responses has improved but response rates requires further work.	Medium	• Introduce a performance improvement trajectory for 30 day complaint responses, to include targets for each Directorate/service group.	CQF Implementation Plan
TOR 9: Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board	**Role of IM's & Executives** An IM development programme is in development, to include the role of the IM as chair of sub-committees of the Board and data analysis. A Board Development programme is in development to strengthen leadership & awareness of accountabilities. Corporate Manslaughter and Homicide Act will be included in the development programme. The Executive Team are currently participating in a team development programme, which is externally facilitated.	Medium	• Finalise and implement the Board Development Programme	Annual Governance Programme

PTHB Self-Assessment of Quality Governance Arrangements for Welsh Government – December 2019

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
1. Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.	Medium	Board to agree: • Clinical Quality Framework (January 2020) • IMTP (January 2020)	
2. The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically: • **The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.** • **The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the management of risk within the organisation.** • **The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework.** • **Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks.**	Medium	• Risk Management and Assurance Toolkit to be published in January 2020 to support all staff in the identification, recording and management of risk • Internal Audit Risk Management review due Q4, 2019/20 • Ongoing implementation of the Annual Governance Programme 2019/20 • Clinical Quality Framework to be agreed by Board (January 2020) • Values and Behaviours Framework to be refreshed for 2020 • Improving Performance Framework to be refreshed for 2020 • Ongoing Implementation of the OD Strategic Framework Action Plan 2019-21 • Further development of Committee Risk Registers	• Annual Governance Programme

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
3. There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: • **The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined** • **The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear** • **There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.**	**Medium**	• Clinical Quality Framework to be agreed by Board (January 2020) • Organisational Realignment Phase 2 to re-establish roles, responsibilities and lines of accountability in relation to quality and patient safety within directorates • Ongoing Implementation of the OD Strategic Framework Action Plan 2019-21 • Ongoing implementation of the Annual Governance Programme 2019/20	• CQF Implementation Plan • OD Strategic Framework • Annual Governance Programme
4. The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively, the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.	**Medium**	• Further development of Committee Risk Registers • Review of management groups through Annual Governance Programme • Review and refresh of Quality Performance Report and KPIs • Committee Annual Self-Assessment of Effectiveness to take place April 2020	• Annual Governance Programme • CQF Implementation Plan

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
5. Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.	Medium	• Ongoing Implementation of the OD Strategic Framework Action Plan 2019-21 • Ongoing implementation of the Annual Governance Programme 2019/20 • Ongoing implementation of the Board and IM Development Plans 2019/20 • Undertake Board Self-Assessment of Effectiveness April 2020	• CQF Implementation Plan • OD Strategic Framework • Annual Governance Programme
6. There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real -time user/ patient feedback.	Medium	• PTHB Engagement Strategic Framework to be refreshed for 2020 • Clinical Quality Framework to Board January 2020 (for approval) – will include domain of patient centred care (patient experience)	• CQF Implementation Plan, including Patient Experience Strategic Framework
7. There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.	Low	• Implementation of Clinical Audit Improvement Plan • Risk based Clinical Audit Plan (2020/21) to be developed • Learning and sharing lessons from Clinical Audit to be strengthened • Clinical Quality Framework to be agreed by Board (January 2020)	• CQF Implementation Plan

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
8. The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.	Medium	• Organisational Realignment Phase 2 to re-establish roles, responsibilities and lines of accountability in relation to quality and patient safety within directorates • Clinical Quality Framework to be agreed by Board (January 2020) • Ongoing implementation of the Annual Governance Programme 2019/20 • Framework for learning to be developed with the engagement of clinicians and staff – as set out in the OD Strategic Framework	• CQF Implementation Plan • OD Strategic Framework • Annual Governance Programme
9. The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have: **Clear remits, appropriate membership and are held at appropriate frequently.** **Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.** **Clarity of the role and decision making powers of the committees.**	Medium	• Ongoing implementation of the Annual Governance Programme 2019/20 • Review of management groups through Annual Governance Programme • Review and refresh of Quality Performance Report and KPIs	• CQF Implementation Plan • Annual Governance Programme

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
10. The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.	**Medium**	• Risk Management and Assurance Toolkit to be published in January 2020 to support all staff in the identification, recording and management of risk • Internal Audit Risk Management review due Q4, 2019/20 • Ongoing implementation of the Annual Governance Programme 2019/20 • Further development of Committee Risk Registers	• Annual Governance Programme
11. The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.	**Low**	• New Datix systems starts implementation from 2020 • 'Intelligence' approach to be finalised for 2020. • Report clinical quality performance mechanisms to be implemented in 2020.	• CQF Implementation Plan

All-Wales Self-Assessments of Quality Governance Arrangements

Recommendations	Self-Assessment (High, Medium, Low)	Plan for future action/review	Status & Mechanism for Delivery
12. The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.	**Low**	• Clinical Quality Framework to be approved by Board in January 2020. This will include a refreshed approach to learning.	• CQF Implementation Plan
13. The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.	**High**	• Values and Behaviours Framework to be refreshed for 2020 • Ongoing Implementation of the OD Strategic Framework Action Plan 2019-21	• OD Strategic Framework
14. The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.	**Medium**	• Ongoing implementation of Board Development Plan • Clinical Quality Framework to Board January 2020	• CQF Implementation Plan • Annual Governance Programme

AGENDA ITEM: 3.4

EXPERIENCE QUALITY AND SAFETY COMMITTEE	DATE OF MEETING: 4 JUNE 2020
Subject :	**Clinical Audit Programme**
Approved and Presented by:	Wyn Parry Medical Director
Prepared by:	Amanda Edwards Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	Quality Governance Group, 21st May 2020

PURPOSE:

There have been a number of challenges relating to the improvement of clinical audit across the Health Board. The purpose of this paper is to provide assurance to the group that clinical audit is being robustly developed and managed.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to DISCUSS and NOTE the content of this report.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The PTHB clinical audit programme requires further improvement, as recognised by Welsh Audit Office and through two "limited assurance" internal audits.

This paper sets out the background to implementing a robust process to oversee the improvements which will provide evidence for assurance. The programme is already underway with plans for and evidence of improvement as well as learning that will be shared across the organisation.

DETAILED BACKGROUND AND ASSESSMENT:

Background

Clinical audit is a systematic cycle - comparing care to specific criteria, taking improvement action if indicated and monitoring the process to ensure improvement is realised and sustained. Clinical audit is, by its nature, comparative and action-oriented, based on high quality, evidence-based clinical standards and encompassing re-audit. Clinical audit should not be simply about measuring clinical activity in isolation; nor should it be about creating local standards, unless by exception (e.g. an area of defined clinical priority, where no suitable evidence-based standards are already available).

The challenges surrounding clinical audit within PTHB are well rehearsed.

The PTHB Clinical Audit Strategy for 2017-2020 was approved by the PTHB Executive Committee on 29 March 2017 and encompassed both the national clinical audit programme and locally-determined clinical audits.

Despite progress made in the determination, management and reporting of clinical audit activity in PTHB before and since the strategy was approved, the Welsh Audit Office Structured Assessment for PTHB for 2017 recognised (page 35) that the clinical audit strategy had not been fully implemented and that there should be "…more robust coordination of the Health Board's clinical audit programme…" In addition, the PTHB clinical audit programme has received two "limited assurance" internal audit ratings (most recently, in February 2018).

In July 2018 a Clinical Audit Improvement Plan was developed and approved by the Executive Committee. Despite the development of this improvement plan, there does not seem to have been a joined up approach to audit or the sharing of any associated learning across the Health Board. Importantly the context that audit works in, one of quality improvement and clinical effectiveness, appears not to have been fully appreciated.

Clinical Audit Programme

To address these issues a Clinical Audit Programme Plan aligned to the Clinical Quality Framework has been developed. This reflects the changes to both the governance arrangements of the Health Board and the organisational realignment.

In summary, the clinical audit programme will:

- Establish the process to plan the clinical audit programme at Directorate/Departmental level, including the prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks) and confirm operational management arrangements.

- Determine and prioritise clinical audit projects, linked to clinical and organisational risk and priorities. Ensure that the following area of clinical audit to be incorporated within the plan; National Audit Programme, Learning from Serious Incidents (SIs) or complaints, new or changes to existing policy / practice and areas where service improvement is required.

- Establish the timeframe and governance arrangements for the sign off of the annual programme of PTHB clinical audit activity for the following

financial year. This is to include the agreed reporting process in terms of timeframes and frequency of reporting during the financial year.

- Set out the timeframe and governance process for the annual report of PTHB clinical audit activity for the previous financial year. This to include the end-of-year reporting of individual audits, including a clear impact statement and any recommendations for change

- Identify the management process to monitor progress and compliance against expected completion dates, track recommendations through to closure, identify where slippage against an expected completion date occurs and ensure that applicable relevant remedial action is taken by the service area and to monitor the remedial action.

- Ensure an appropriate audit trail for changes to the clinical audit plan to include the tracking of all changes together with a rational and justification for the changes.

A copy of the Clinical Audit Programme Plan can be found at **Appendix A**.

Embedding Clinical Audit in Clinical Effectiveness and Quality Improvement

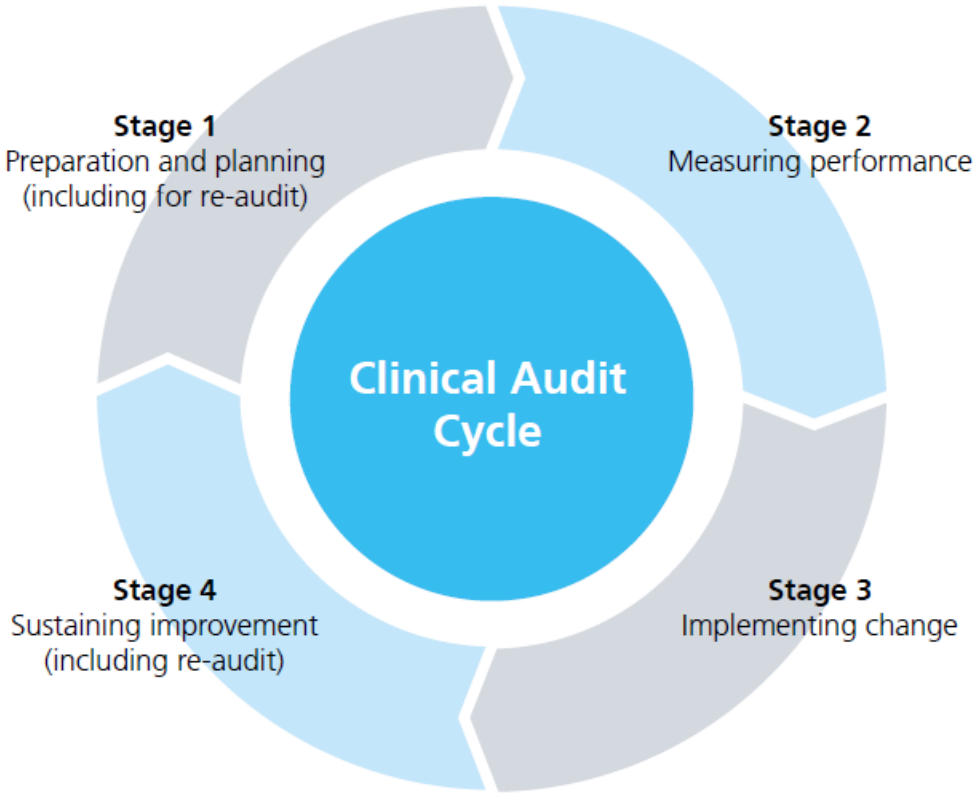
Experience, Quality and Safety (EQ&S) Terms of Reference specifies the "…arrangements…" for the provision of high quality, safe and effective healthcare on which the EQ&S will seek assurance – including, but not limited to: clinical audit, internal and external reviews, the PTHB AQS and "focused" quality performance indicators and metrics.

NICE defines Clinical audit as: 'A process for monitoring standards of clinical care to see if it is being carried out in the best way possible ("best practice").

Clinical audit is a systemic cycle-comparing care to specific criteria, taking improvement action if indicated and monitoring the process to ensure improvement is realised and sustained. Clinical audit is, by its nature, comparative and action orientated, based on high quality, evidence based clinical standards and encompassing re-audit.

Clinical audit should not be simply about measuring clinical activity in isolation; nor should it be about creating local standards, unless by exception e.g. an area of defined clinical priority, where no suitable evidence based standards are already available.

According to the results, adjustments are then made to the pathway and the whole audit repeated: this is the audit "cycle".



Previous Clinical Audit plans have been very long and have attempted to audit a wide range of areas. PTHB are keen to reduce the number of Clinical Audits to
-make the plan more achievable
-ensure a focus on agreed key areas
-ensure a focus on clinical effectiveness and quality improvement
-establish and facilitate shared learning

Although the principles of good quality clinical audit have remained unchanged, the context in which clinical audit is carried out has evolved. There is now a greater understanding and appreciation of the relationship between clinical audit and other quality improvement activities.

Clinical effectiveness is an umbrella term describing a range of activities that support clinicians/health care professionals to examine and improve the quality of care. Probably the best known example is clinical audit, but effectiveness stretches beyond this to include the implementation of nationally agreed guidance as well as agreed standards/clinical performance indicators reflecting 'best practice' (where these exist and are relevant to our services). Its purpose is not only to provide assurance but also to suggest ways in which to improve.

The current Clinical Audit Strategy has been reviewed by the Clinical Leadership Group (CLG) in May 2020. Feedback is that
-it is clear with valid realistic action plans.
-has a clear framework
-allows a structured approach to an audit programme
-aligns with national guidelines
-that there is a clear plan for sharing outputs from audits across wide areas.

A copy of the current Clinical Audit Strategy can be found at **Appendix B**

Clinical Audit Plan 2020 / 21

A Clinical Audit Plan will be drafted for 2020 / 21 which incorporates within the plan:

- National Audit Programme elements as they apply to PTHB
- Learning from Serious Incidents (SIs) or complaints
- New or changes to existing policy / practice and areas where service improvement is required.
- The prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks

This formal plan will be signed off by end of May 2020. A draft copy of this Clinical Audit Plan can be found at **Appendix C.** Two directorates (Mental Health and Women and Children) are already underway with the plan.

Next Steps

Already underway

- Developing and implementing the Clinical Audit Programme to reflect changes in the reporting structure, operational groups and taking account of changes as a result of the organisational realignment

By May 2020

- To sign off Clinical Audit Plan 2020
- To develop a robust process to oversee the management of the clinical audit process and provide assurance to the Health Board that this has been effectively implements delivered.
- To develop a Clinical Effectiveness and Quality Improvement Strategy in line with the Clinical Quality Framework.

PTHB Clinical Audit Programme

2020 / 21

	Action	Lead	Supported by:	Delivery Deadline	RAG Status
1	Ensure identify the lead officer with responsibility for clinical audit and development of the programme and ensure that this is fully reflected in their job description	Medical Director		31.3.20	
2	Develop the Clinical Audit Programme Plan	Assistant Director Innovation &Improvement		31.4.20	
3	In line with the Clinical Quality Framework, agree the governance arrangements for the annual clinical audit cycle	Assistant Director Innovation &Improvement	Board Secretary	31.5.20	
4	Following approval of the Clinical Audit Programme at QGG and EQ&S, launch the clinical audit programme through a targeted communication to all key staff	Assistant Director Innovation &Improvement	Assistant Director Comms & Engagement	31.5.20	
5	Integrate clinical audit into a wider programme of quality improvement and service development; moving towards full integration of all aspects of service improvement by reviewing the current Clinical Audit Strategy and incorporate it within the Clinical Effectiveness and Quality Improvement Strategy	Assistant Director Innovation &Improvement		30.6.20	
6	To ensure the following area of clinical audit to be incorporated within the plan: ▪ National Audit Programme – these will be populated centrally ▪ Learning from Serious Incidents (SIs) or complaints ▪ New or changes to existing policy / practice ▪ Areas where service improvement is required	Assistant Director Innovation &Improvement	Safety & Quality Improvement Manager Service / Clinical Leads	30.6.20	

7	Each service area to agree at least one clinical audit per annum which is based on NICE guidance/NICE quality standards	Safety & Quality Improvement Manager	Service / Clinical Leads	30.9.20	
8	The annual programme of PTHB clinical audit activity for the *following* financial year to be signed off by PTHB Executive Committee (prior to QGG / EQ&S) no later than the January of the *previous* financial year (to encompass a rational balance of new and follow-up clinical audits; and anticipated completion dates for each audit)	Medical Director	Safety & Quality Improvement Manager Service / Clinical Leads	31.12.20	
9	The annual report of PTHB clinical audit activity for the *previous* financial year to be signed off by PTHB Executive Committee (prior to QGG / EQ&S) no later than the June of the *following* financial year	Medical Director	Safety & Quality Improvement Manager Service / Clinical Leads	31.8.20	
10	Enhance senior clinical leadership for clinical audit through clinical Executive sponsorship for key audits (at least one clinical audit per clinical Executive, to be agreed as part of the clinical audit annual planning process)	Medical Director	All executives	30.6.20	
11	Confirm a lead clinician and lead manager for clinical audit for each Directorate/Service Area	Safety & Quality Improvement Manager	Service / Clinical Leads	31.3.20	
12	Develop a dedicated and regularly updated area for clinical audit on the PTHB intranet site (to include library of evidence-based clinical standard sets; other web-based support materials for clinical audit; and contact details for lead staff at PTHB corporate and Directorate level)	Safety & Quality Improvement Manager	Assistant Director Comms & Engagement	31.7.20	

13	Establish an agreed process to: ▪ Plan the clinical audit programme at Directorate/Departmental level, including the prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks)	Medical Director	Assistant Director Innovation &Improvement Safety & Quality Improvement Manager	30.4.20	
13.1	▪ Confirm operational management arrangements	Safety & Quality Improvement Manager		31.5.20	
13.2	▪ Monitor progress and compliance against expected completion dates ▪ Track recommendations through to closure ▪ Identify where slippage against an expected completion date occurs and ensure that applicable relevant remedial action is taken by the service area ▪ Monitor the remedial action	Safety & Quality Improvement Manager		30.6.20	
13.3	▪ Ensure an appropriate audit trail for changes to the clinical audit plan to include the tracking of all changes together with a rational and justification for the changes.	Safety & Quality Improvement Manager		30.6.20	
13.4	▪ Establish the agreed reporting process in terms of timeframes and frequency of reporting ▪ The end-of-year reporting of individual audits, including a clear impact statement and any recommendations for change	Safety & Quality Improvement Manager		30.6.20	
13.5	▪ Develop related materials to support discussion and prioritisation of clinical audit through the PTHB PADR process	Assistant Director Workforce & OD	Assistant Director Innovation &Improvement	30.6.20	

14	Define/develop role of PTHB primary care in supporting national primary care clinical audits	Assistant Medical Director	Assistant Director Primary Care	30.6.20	
15	To review National Clinical Audits as they would apply to PTHB commissioned services where and support PTHB Commissioning Team in interpreting/addressing any actions required.	Safety & Quality Improvement Manager	Assistant Director Commissioning Development	30.4.20	
16	Raise the profile of the clinical audit programme (both national and local projects) in PTHB through a programme of communication and engagement with staff and service users.	Safety & Quality Improvement Manager	Assistant Director Comms & Engagement	31.5.20	
17	Clinical audit activity to be consistently reported as part of Directorate review processes	Board Secretary	Execs	30.6.20	
18	Develop a SOP to support the PTHB response (including actions) to all national clinical audits, whether in PTHB provided or commissioned NHS services	Safety & Quality Improvement Manager		30.6.20	
19	To complete a clinical audit training needs assessment for PTHB staff and develop the training offer to meet these defined needs	Safety & Quality Improvement Manager	Clinical Education Manager	30.6.20	
20.	Explore QA Tracking for the electronic monitoring of clinical audit	Assistant Director Innovation &Improvement	Head of Risk & Assurance	30.6.20	

The following PTHB-defined RAG ratings are used to indicate position against actions:

R	Red		Persistently not meeting objective/target (at least 3 months) and highly unlikely to meet objective/target within specified period
A	Amber		Persistently not meeting objective/target, but on an agreed performance improvement trajectory
G	Green		Objective/target achieved
B	Blue		Task completed

Clinical Audit Strategy 2017 -2020

Powys THB is committed to providing safe and high quality clinical care. The THB recognises the important contribution of clinical **audit** to the wider clinical governance agenda for improving the standard **of clinical** practice.

This document outlines a strategy to develop the range and quality of clinical audit to provide the most effective contribution to the Boards assurance processes and quality improvement activities for the next three years. This will support the organisation's strategic objective of creating a culture that places the patient first in everything that is done and enables and encourages continuous improvement in safety, quality and the patient experience in all care settings.

The Strategy also addresses the 4 high and 3 medium priority recommendations of an Internal Audit Report 2016/17 (detailed at Appendix

Powys Teaching Health Board: Clinical Audit Strategy 2017-2010

Background

Clinical audit is a quality improvement method which has seen widespread use since its formal introduction into UK practice by the 1989 White paper "Working for Patients".

The National Institute of Health and Clinical Excellence defines Clinical Audit as "*a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards*".

1.0 Aims of the Clinical Audit strategy

The aim of this Strategy is to ensure that an effective programme of clinical audit is embedded across all parts of the organisation and that the content of the audit programme remains relevant to the clinical and organisational priorities over the next 3 years.

The strategy supports the organisational commitment to continuous improvement through the measurement of evidence based practice.

There are five interwoven threads to the strategy:

1.1 Assurance

The clinical audit strategy will ensure that robust information is collected to provide assurance within the organisation and for external partners that: -

- The quality of local care is judged against recognised standards
- Areas for improvement are identified through a systematic approach

1.2 Improvement
The clinical audit strategy will support organisational compliance with Health and Care Standard 3.3 by demonstration of a robust process programme of continuous quality improvement, reducing waste and addressing inefficiencies. The Strategy prioritises a commitment to learn from and act upon audit findings.

1.3 Patient experience
Patient experience is central to our assessment of service quality and will be used to inform the quality assurance and improvement programmes.

1.4 Alignment
The content of the Audit Programme will be aligned to the strategic goals of the organisation to promote and develop a modern model of rural healthcare centred on the needs of the individual.

1.5 Value
Clinical audit activity will guide the deployment of staff and resources to manage risk, improve quality and promote efficiency.

2.0 Objectives of the Clinical Audit strategy

2.1 To ensure that organisational structures and processes are fit for purpose

The proposed structure for the Clinical Audit Programme builds on the existing framework but in addition incorporates recommendations from the Internal Audit report.

The delivery of the audit programme is supported by the following processes: -

- Development and approval of the Clinical Audit Plan
- Delivering audit activity
- Reporting of clinical audit results, actions and impact
- Refection, learning and sharing
- Review and refresh of the plan

Strategy Action Points	By (Date)
• Agree the content of the organisational Clinical Audit Strategy annually	April each year
• Delivery of audit activity	Determined by each audit
• Reporting of activity	Annual Audit Report September
• Refresh of the audit plan	April each year or as needed

2.2 To ensure that organisational responsibilities are clearly articulated

Clinical audit is a core element of professional practise. Clinicians and managers should regularly review appropriate data to assess the quality of care provided and to identify opportunities for improvement. Organisational support for audit activity enables clinicians to fulfil their professional duties, supports managers to quantify improvement and provides the organisation with a valuable assessment of the quality of care provided.

Strategy Action Points	By (Date)
• The roles, responsibilities and contact details of staff engaged with leading and developing audit to be shared on a dedicated area of the Health Board intranet site	April 2017
• Clinical audit to be a key priority in individual and team objectives	Ongoing
• Clinical audit and other quality improvement activity to be agreed within personal objectives and reviewed during appraisal	Ongoing

2.3 Training

The organisation values clinical audit and will ensure that resources for training and advice are available to support and encourage audit activity.

Strategy Action Points	By (Date)
• Web based materials to support clinical audit will be made available	By April 2017
• Managers will assess the specific training of their staff and build the training need assessments into their forward plans.	To be assessed annually

• As far as possible clinical audit reports should follow an agreed standardised format that has been created and is currently out for consultation with all staff groups.	

2.4 Development and approval of the clinical audit plan

National audits will be reviewed by the Medical Director and Safety and Quality Improvement Manager after the publication of the National Clinical Audit and Outcome Review (NCAOR) Programme to confirm local relevance- where appropriate these will be included in the Annual Plan. Powys actions arising from all NCAOR audits will be formally reported to Welsh Government in the format, and to the timescales, determined by them.

Directorates will develop a short list of potential clinical audit topics. As a body of work clinical audit should support the strategic aims and objectives of the organisation. A number of sources will inform which subjects should be selected for the clinical audit plan. These will include nationally mandated audits, incidents, risks and concerns, patient feedback and outcome reported measures. Particular attention should be paid to areas of clinical practice where there is clear evidence of what constitutes good practice such as NICE guidance. The Director with responsibility for each clinical service should have oversight of the audit plan development process and of the list of selected clinical audits.

Strategy Action Points	**By (Date)- Annual cycle**
• Each clinical directorate to develop a draft clinical audit plan	February
• The OMG Audit Sub-group to provide advice, review proposals and offer feedback to individual Directorates	March
• The OMG Audit Sub-group to provide an analysis of the draft THB programme (including national requirement and local proposals) and propose a draft Annual Audit Plan for the consideration of the OMG group	April
• **The content of the programme to be tested against SMARTER criteria.** ○ **Specific** ○ **Measurable** ○ **Achievable** ○ **Relevant** ○ **Time-limited** ○ **Evaluated** ○ **Resourced**	April

• The OMG Group to agree the Annual Clinical Audit Plan and ensure that the delivery of the plan is supported by appropriate resource. • Report to the Patient Experience Quality and Safety Committee	April September

The Operational Management Group will ensure that all areas of the organisation are considered in the PTHB Clinical Audit Plan and that the importance of assurance across the whole of the patient journey is recognised.

Strategy Action Points	**By (Date)**
• Approval of the clinical audit plan as a rolling programme by the Operational Management Group	Annual - April

2.6 Action plans and monitoring

The audit process must include reflection on the findings and development of actions where appropriate. This intelligence will inform the priorities and objectives of the OMG.

Improvement actions will be reported and barriers to delivery will be managed via risk registers.

Feedback and sharing of learning will be supported by activities such as newsletters and educational events.

Strategy Action Points	**By (Date)**
• The results of clinical audit will drive the necessary improvement actions for clinical services	The success of this process should be reviewed every six months
• Progress against the Annual Audit Plan will be monitored via the OMG and an Annual Audit Report will be published	September
• Teams/Directorates will be encouraged to hold developmental or celebratory events that support clinical audit and other quality improvement activities.	Ongoing

Primary, Community & Mental Health Care Services Directorate				
Community Nursing				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	Pulmonary Rehabilitation	TBC	CSM South	TBC
National Audit Programme	Cardiac Rehabilitation Audit	Ongoing database	AD Community Services	TBC
Serious Incident Learning	DNACPR Audit	TBC	Head of Nursing	TBC
Serious Incident Learning	NEWS Chart use Audit	TBC	Head of Nursing	TBC
Mental Health				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Service Improvement required	Clozapine and physical health audit	Jan-20	Dr Sadid	Jul-20
Service Improvement required	Audit of prescription charts against BNF standards	Mar-20	Clinical Director Mental Health and Learning Disabilities	TBC
Changes to existing policy or practice	Mental Health Act Documentation	Mar-20	Clinical Director Mental Health and Learning Disabilities	TBC
Changes to existing policy or practice	ECGs undertaken on Older Adult Mental Health in-patient units	TBC	Advanced Nurse Practitioner	TBC
Serious Incident Learning	Care and Treatment Plan (CTP) audit	Jan-20	Senior Manager, Adult Mental Health Montgomeryshire	TBC

Service Improvement required	Tawe Ward CTP audit	Jan-20	Ward Manager	Reporting started
National Audit (Non-Programme)	Tawe Ward IPC audit	Jan-20	Ward Manager	Reporting started
Changes to existing policy or practice	Tawe Ward Prescription audit	Jan-20	Ward Manager	Reporting started
Service Improvement required	NICE Guideline Dementia Ystradgynlais Older Adult CMHT	TBC	Community Mental Health Nurse	TBC
Serious Incident Learning	Audit of the Joint Working Protocol between adult substance misuse services and adult mental health services.	Feb-20	Service Manager - Adult Mental Health (North Powys)	TBC
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit (Non-Programme)	WHTM01-05	Apr-20	Senior Dental Therapist	Jul-20
National Audit (Non-Programme)	Patient Experience Questionnaire (CDS)	May-20	Dentist	Aug-20
National Audit (Non-Programme)	Patient Experience Questionnaire (Oral Surgery)	Mar-20	Dental Nurse Oral Surgery Team Lead	Jun-20
Service improvement required	Radiography grading	Continuous yearly run chart	Dental Director	Continuous yearly run chart
Service improvement required	Hand Hygiene	April 2020 and Oct 2020	Senior Dental Therapist	May 2020 and Nov 2020
Service improvement required	Clinical record keeping	Nov-20	Dentist	TBC

Service improvement required	Clinical record keeping (special care)	Mar-20	Specialist in Special Care	TBC
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
	Awaits			
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Core Audit	TBC	Remote audit of GP computer system	TBC
Service improvement required	Patient Safety Programme	Sept 19	Prescribing lead within each practice	Sept 20
Service improvement required	Reducing Stroke risk through improved management of AF in primary care clusters	Sept 19	Lead GP	Sept 20
Service improvement required	Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)	Sept 19	Antibiotic lead	Sept 20
Service improvement required	Diabetes Gateway	Apr 20	Diabetes lead	Dec 20
Women's and Children's Service				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Maternity and Perinatal Audit	TBC	Head of Midwifery	TBC

National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People	TBC	Consultant Community Paediatrician	TBC
Child Protection Quality Standards (UK)	Child Protection Medicals in Powys	TBC	Consultant Community Paediatrician	TBC
FOI request re FASD	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	TBC	Consultant Community Paediatrician	TBC
Therapies and Health Sciences Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Foot Care Audit	TBC	Head of Podiatry	TBC
National Audit Programme	All Wales Audiology Audit	TBC	Head of Audiology	TBC
National Audit Programme	Stroke Audit (SSNAP)	Ongoing	Professional Head Physiotherapy	ongoing
Service improvement required	OT Documentation	Apr-20	Head of Therapies	Sep-20
Service improvement required	Documentation audit	TBC	Head of Podiatry	TBC
Service improvement required	Taxonomy audit	TBC	Head of Podiatry	Mar-21

Service improvement required	NICE Audit Low Back Pain	Dec-20	Clinical Specialist Physiotherapist	Mar-21
Service improvement required	Clinical Notes audit - Pain and Fatigue service	Nov-20	Clinical Specialist Physiotherapist	2021
Service improvement required	Parkinson's Care	2021	PD UK	2021
Service improvement required	SLT notes	2020 - 2x yearly	Head Adult Speech & Language	TBC
Audit for re-accreditation	Radiography: Non-medical referrers audit	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Compliance with Standard operating procedures (SOP's)	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Compliance with gonad protection standards	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Reject analysis	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Recording of date of last menstrual period	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Correct use of radiographic markers	TBC	Team Lead/ Supt Radiographer	TBC
Audit for re-accreditation	Radiographer commenting audit	TBC	Team Lead / Supt Radiographer	TBC
Service improvement required	Physiotherapy Notes	TBC	Professional Head Physiotherapy	TBC
Service improvement required	CMATS- referral management	TBC	Professional Head Physiotherapy	TBC

Nursing Directorate				
Driver	Audit Title	Start Date	Lead	End Date
Serious Incident Learning	Falls Audit	Q3 2020	Assistant Director of Nursing	End Q4 2020
Service improvement required	Fundamentals of nursing care	Q4 2020	Assistant Director Quality & Safety	Q1 2021
Serious Incident Learning	Pressure Ulcer Prevention	Q3 2020	Assistant Director Quality & Safety	End Q4 2020
Serious Incident Learning	Compliance with the serious incident policy	Q4 2020	Assistant Director Quality & Safety	End Q4 2020
Safeguarding				
Driver	Audit Title	Start Date	Lead	End Date
Service improvement required	Safeguarding Maturity Matrix	Jul-20	Assistant Director Safeguarding	Sep-20
Service improvement required	Safeguarding Supervision Audit	Dec-20	Senior Nurse Safeguarding	Feb-21

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident
	Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.5

EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 4 June 2020**
Subject:	**Safeguarding Update**
Approved and prepared by:	Executive Director of Nursing and Midwifery
Other Committees and meetings considered at:	This paper is based on the agenda and discussion undertaken within the Safeguarding Group, Quality Governance Group

PURPOSE:

The purpose of this paper is to:

- Identify the intention to further develop the health board's strategic response to safeguarding and public protection

RECOMMENDATION:

The Experience Quality and Safety Committee is asked to DISCUSS and NOTE the contents of this paper.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Safeguarding Group met on 12 May 2020. Following the last meeting in February 2020, members of the group generated ideas and reflections on the way in which the safeguarding and public protection agenda could be strengthened and enabled within the health board.

Th group reeved a mixture of existing and new agenda items for consideration, recognising the good practice evidenced during the covid19 pandemic and progress made in achieving a range of actions contained within the action log, some of which had been open for some time.

Although slightly delayed as a result of the covid19 pandemic, the intention remains to be able to provide a strategic perspective form the safeguarding group that will help inform the workplan and wider business of the health board. Agreeing the need to balance the agenda to include a population wide on focus safeguarding and public protection, as well as a national and local perspective, with a strong multi-agency foundation.

DETAILED BACKGROUND AND ASSESSMENT:

The Safeguarding Group met on 12 May 2020. Following the last meeting in February 2020, members of the group generated ideas and reflections on the way in which the safeguarding and public protection agenda could be strengthened and enabled within the health board. The group considered the

means by which it could better accommodate the strategic and operational matters through structure, lines of reporting and accountability and the Head of Safeguarding will implement the revised arrangements during June 2020.

Th group reeved a mixture of existing and new agenda items for consideration, recognising the good practice evidenced during the covid19 pandemic and progress made in achieving a range of actions contained within the action log, some of which had been open for some time.

The group received a report detailing the way in which safeguarding had been managed, based on national guidance, during COVID 19and were advised that whilst the health visiting and school nursing service had been largely deployed, a paper had been prepared detailing the need to re-establish the service as soon as possible, given the growing evidence base in relation to wider societal harm.

The approach taken to provision of training was noted as exceptionally good practice, with videos developed to maximise the opportunity and accessibility of safeguarding training for staff.

Whilst new items on the agenda, a verbal update was provided regarding safeguarding within adult in patient settings, with a view to formalising the focus and extending to community settings, for adults with physical ill health, as well as those with mental illness and others with learning disability. Safeguarding in care homes also featured on the agenda for the first time and this item will become a standing agenda item, along with others which will feature in the operational and strategic group agendas as per revised terms of reference, the latter being presented to the next quality governance group.

The need for accurate data and intelligence to help inform the forward plan of the group was identified, to include themes and trends related in incidents, concerns and claims specific to safeguarding and public protection. A draft report will be available for the next meeting.

The Perinatal and Child Health Action Plan 2019 was presented, noting the way in which learning was being embedded into practice. Public Health Wales colleagues provided a brief update and feedback was shared from the Regional Partnership Board.

Although slightly delayed as a result of the covid19 pandemic, the intention remains to be able to provide a strategic perspective form the safeguarding group that will help inform the workplan and wider business of the health board. Agreeing the need to balance the agenda to include a population wide on focus safeguarding and public protection, as well as a national and local perspective, with a strong multi-agency foundation.

NEXT STEPS:
Although slightly delayed as a result of the covid19 pandemic, the intention remains to be able to provide a strategic perspective form the safeguarding group that will help inform the workplan and wider business of the health board. Agreeing the need to balance the agenda to include a population wide on focus safeguarding and public protection, as well as a national and local perspective, with a strong multi-agency foundation.

AGENDA ITEM: 3.6

EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 4 JUNE 2020**
Subject:	**Infection, Prevention & Control Update**
Approved and prepared by:	Executive Director of Nursing and Midwifery
Other Committees and meetings considered at:	This paper is based on the agenda and discussion undertaken within the Infection Prevention and Control Group and the Decontamination Group, Quality Governance Group

PURPOSE:

The purpose of this paper is to:

- Identify the need and intention to further develop the health board's strategic response to infection prevention, control and decontamination

RECOMMENDATION:

The Experience Quality and Safety Committee are asked to DISCUSS and NOTE the contents of this paper.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The scope and focus embedded with the umbrella term of infection, prevention and control (IPC) has exponentially increased in a relatively short space of time. The infection prevention and control group met on 28 April 2020, with widespread representation from many areas of the health board.

The meeting provided an environment whereby members were able to share with others work and focus by department and identified there are a number of opportunities to strengthen this agenda. It was agreed that a whole team development session would be beneficial to review and revise the way in which infection prevention and control, and decontamination could be strengthened, enabling oversight, scrutiny, assurance and forward planning, ensuring the group is well positioned to influence and shape as need be. The session is scheduled for July 2020.

DETAILED BACKGROUND AND ASSESSMENT:

The scope and focus embedded with the umbrella term of infection, prevention and control (IPC) has exponentially increased in a relatively short space of time. Notwithstanding the covid19 global pandemic, there are a range of key areas of focus including standard infection control precautions, antimicrobial resistance / multi-drug resistant organisms (MDRO), aseptic non-touch technique (ANTT), cleaning and decontamination, healthcare associated infections, water and waste management.

Although in the midst of the covid19 pandemic, the infection prevention and control group met on 28 April 2020, with widespread representation from many areas of the health board. Contributions identified that progress had been made in a number of areas, including environmental cleanliness whereby daily audits have been introduced in clinical areas and compliance with enforcement orders related to water management.

Less progress had been made with regard to the workplan of the Decontamination Group, consensus with the dental department in terms of necessity for training and exploration of the Welsh Government's decontamination audit, approval of the management of MRSA pathway and the uptake of aseptic non-touch technique training. The lack of opportunity to develop a community focus relating to antimicrobial resistance and continued challenge in obtaining timely electronic data from commissioned services in Shrewsbury and Telford were also tabled. The opportunity to synergise the action plans currently in existence, was agreed including a refreshed focus on improvement. Formalising links into the group from the service groups and therefore develop a clear line of sight to and from Board, was also identified.

The meeting provided an environment whereby members were able to share with others work and focus by department and identified there are a number of opportunities to strengthen this agenda.

NEXT STEPS:

It was agreed that a whole team development session would be beneficial to review and revise the way in which infection prevention and control, and decontamination could be strengthened, enabling oversight, scrutiny, assurance and forward planning, ensuring the group is well positioned to influence and shape as need be. The session is scheduled for July 2020.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

Experience, Quality & Safety Committee	**Date of Meeting: 4th June 2020**
Subject :	**Risk Assessment: Transmission of COVID-19 in the workplace**
Approved and Presented by:	Julie Rowles, Director of Workforce, OD & Support Services
Prepared by:	Stuart Bourne, Director of Public Health and Sarah Powell, Assistant Director of Workforce and OD
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this report is to provide an update on the Health and Safety arrangements, to support the prevention of staff being at risk of contracting COVID-19 whilst in the workplace. There are a number of Directors with responsibility for ensuring control measures are in place, to enable safe systems of work and practice. This paper provides an overall risk based approach based on the actions taken to date, along with making reference to aspects that require further work or assurance.

RECOMMENDATION(S):

It is recommended that the Experience, Quality & Safety Committee discusses and notes the key contents of this update paper and the further actions required, to ensure risks to staff in transmitting COVID-19 are identified and managed effectively, in line with the Health and Safety Executive, Welsh Government and Public Health Wales legal requirements and guidance.

Approval/Ratification/Decision[1]	Discussion	Information
✖	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓/✖
	2. Provide Early Help and Support	✓/✖
	3. Tackle the Big Four	✓/✖
	4. Enable Joined up Care	✓/✖
	5. Develop Workforce Futures	✓/✖
	6. Promote Innovative Environments	✓/✖
	7. Put Digital First	✓/✖
	8. Transforming in Partnership	✓/✖
Health and Care Standards:	1. Staying Healthy	✓/✖
	2. Safe Care	✓/✖
	3. Effective Care	✓/✖
	4. Dignified Care	✓/✖
	5. Timely Care	✓/✖
	6. Individual Care	✓/✖
	7. Staff and Resources	✓/✖
	8. Governance, Leadership & Accountability	✓/✖

EXECUTIVE SUMMARY:

The Health and Safety Executive (HSE) is clear about the Employer responsibilities to protect staff from harm, including taking reasonable steps to protect workers from contracting coronavirus. Employers should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work Act 1974.

Both the employer and employees have a duty of care to ensure they have the appropriate processes and practices in place, to reduce risks of exposure to COVID-19 in the workplace.

The Health Board is addressing its responsibility to this requirement through the governance arrangements for COVID-19 and the wider Health and Safety group.

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

There are a number of employee wellbeing issues relating to COVID-19 which the Health Board has addressed at pace e.g. the ability for staff to work from home where they can, the Occupational Health service operating over 7 days a week, Staff Testing etc.

A number of measures have been put in place in line with HSE, Welsh Government and Public Health Wales guidance, an example of these include;

- the implementation of social distancing measures, including shielding where appropriate
- the provision of advice and guidance relating to Infection Prevention Control (IPC) along with training in personal protective equipment (PPE)
- a review of staff well being initiatives and the undertaking of a wellbeing staff survey
- risk assessments are being reviewed and updated both at an organisational and service area levels

Through the Corporate Risk Register process, the Health & Safety function are working with Managers and Directors to ensure Health & Safety risks are identified and that actions and mitigation are robust and embedded. Where appropriate further actions are being developed to address any gaps in assurance.

DETAILED BACKGROUND AND ASSESSMENT:

Since the outbreak of the coronavirus in the UK and in order to support the effective management of Health and Safety Risks relating to our employees, PTHB has undertaken a range of work to ensure that we can provide our staff with information, instruction and training to fulfil our HSE (COVID-19) legal requirements.

PTHB has dedicated Health and Safety intranet pages for COVID-19 which have sections for Staff and Managers, providing information and guidance such as: Risk Assessments, Home Working, PPE etc.

Through daily briefs/cascades and the SITREP, PTHB are able to ensure that appropriate information is provided and cascaded throughout the workforce.

PTHB have issued notice boards and posters relating to COVID-19, Hand Hygiene; Catch it, Kill it, Bin it; IPC, along with additional hand sanitiser stations etc.

A section within the Corporate COVID-19 Risk Register has been collated for Health and Safety **009- COVID19 may be transmitted in the workplace**.

The status of the identified issues and risks within the register will form part of the Health and Safety Group agenda and will be reported through to the Executive Team.

The Health Board has put in place a number of systematic actions to support and address the risks to staff of COVID-19. These include:

Staff wellbeing: lead by DWOD

- Support and advice from Occupational Health (working 7 days a week)
- Ensure PTHB have suitable welfare facilities for changing, taking into consideration the potential need for extra staff accommodation
- Testing and support to all staff who are symptomatic
- Wellbeing Refreshment hubs (initially sponsored by Trade Unions) at each Hospital site
- Wellbeing staff survey undertaken and an enhanced suite of wellbeing offers

Personal Protective Equipment (PPE): lead by DPH and DoN

- A PPE Coordination Group has been established to coordinate the effective use of PPE equipment.
- The Coordination Group uses a World Health Organisation strategic framework based on three aims: minimising the need for PPE, ensuring PPE use is rational and appropriate and coordinating supply chain mechanisms.
- UK guidance on how and when to use PPE has been communicated to staff through different channels, including posters, training sessions and staff announcements.
- An internal learning and training package has been developed to help staff use PPE safely and appropriately.
- There is a network of infection prevention and control (IPC) leads in service areas to help disseminate messages about IPC and PPE.
- The supply of PPE is centrally managed to help coordinate the supply chain.

Training and communications: lead by DWOD and DoN

- H&S Advice and Guidance to employees, supervisors and managers through the COVID-19 H&S intranet pages
- Guidance to Managers and Supervisors for vulnerable employees and dedicated risk assessment template
- Regular Staff updates and bulletins regarding COVID-19
- Regular dialog with the Trade Unions on matters of H&S
- Additional upskilling sessions for clinical staff
- The provision of hand washing advice/guidance and posters in all areas

Policy, guidance and processes: lead by DWOD and DoN

- Controls for social distancing including, where possible, working differently, working from home and providing advice and guidance in settings where this cannot be achieved
- H&S continue to provide PPE information in line with PHW to Managers, Supervisors and employees through the H&S COVID-19 website
- The review and update by operational teams of risk assessments and safe systems of work or SOP'S taking into consideration the risks posed by COVID-19 and implementation of suitable mitigation
- Risk assessment process for all vulnerable groups including BAME specific risk assessment (see Appendix 1)
- The provision of suitable advice and guidance for the laundering uniforms
- Review and update of relevant local policies and guidance in line with National guidance / HSE guidance

Led by the Director of Workforce a working group has also been established to ensure safe systems of working are maintained for patients and staff as services are reviewed in light of COVID-19 and the phase 2 management plan. The Director of Primary Care, Community and Mental Health and Director of Planning and Performance are also leading key aspects of the work programme, to ensure that the safety of staff and patients is maintained as services are re-established.

Managers are also being asked to ensure that risk assessments relating to COVID-19 are updated and any specific issues are escalated through local management forums and, where appropriate the Health & Safety Group and then through to the Corporate Risk Register.

There are still some issues that are being further reviewed at the time of writing this paper these include:

1. An SBAR on the reporting of RIDDOR will be presented at CCF on Friday 29th May 2020 to seek approval for an internal process for reporting of RIDDOR reportable employee cases. This process will be underpinned by the All Wales flow chart and toolkit when approved and released.

2. Alongside the 6 PTHB trained staff we have received confirmation that an additional 6 staff who were trained by Cwm Taf Health Board and Public Health Wales were trained by HSE approved trainers. We are currently awaiting confirmation from Hywel Dda Health Board.

An agreed consistent process for training and recording is now in place as follows :

- PPE Face Fit Test (Qualitative fit test report) including fails and re-tests to be retained by the employer for a min of 5 years. Copy to employee.
- ESR updated employee record.

- Confirmation of what PPE was used during the test, e.g. goggles, glasses face shield etc.
- Fit testing log sheet.
- Face fit tester's information.

Further work is being undertaken to ensure training to date has been delivered in accordance with above and re-fit testing will take place where there has been a change in the use of PPE / goggles, in line with HSE guidance.

NEXT STEPS:

PTHB will :

- Continually monitor and review risk assessments via the Health & Safety Group
- Ensure any safety issues identified from Tiger Eye products are escalated and addressed
- Ensure the approach for RIDDOR reporting is discussed at CCF and GOLD Group
- Ensure any remedial actions are taken if necessary in relation to Face Fit Testing

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age					
Disability					
Gender reassignment					
Pregnancy and maternity					
Race					
Religion/ Belief					
Sex					

Sexual Orientation					
Marriage and civil partnership					
Welsh Language					

Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
Clinical					
Financial					
Corporate					
Operational					
Reputational					

APPENDIX 1

Subject :	**Black, Asian and Minority Ethnic (BAME) staff**
Approved and Presented by:	**Julie Rowles, Director of Workforce, OD and Support Services**
Prepared by:	**Karolina Kobylnik, Workforce Strategy, Policy and Performance Manager**

PURPOSE:

The purpose of this paper is to update the Experience Quality and Safety Committee on the steps taken to support Black, Asian and Minority Ethnic (BAME) staff in relation to being in the high risk category of COVID-19.

BACKGROUND AND ASSESSMENT:

The British Association of Physicians of Indian Origin (BAPIO) has raised concerns about the disproportionately high BAME death rates among health and social care workers in England and Wales. They have also highlighted that people from BAME backgrounds have higher rates of underlying health conditions, such as visceral obesity, diabetes and metabolic syndrome, hypertension and ischemic heart disease, chronic lung disease including asthma, COPD, URTI and vitamin D deficiency and for these reasons may have increased vulnerability. BAPIO also advised that the available figures suggest that being male, BAME and an older adult along, with at least one co-morbid condition, puts them at greater risk of death.

BAPIO has asked NHS Organisations to take a risk assessment approach, to mitigate the risk of further BAME Health and Social Care workers dying from COVID-19, during the pandemic.

On 21st April 2020 Mark Drakeford, First Minister issued a Written Statement: COVID-19 and BAME Communities, on the emerging evidence of the disproportionate impact that COVID-19 is having on some individuals from BAME backgrounds. Powys Teaching Health Board, following a Welsh

Government directive will complete, the approved risk assessments (Appendix 2).

At a Welsh Government daily press briefing on 23rd April 2020 the NHS Wales Director General of Health and Social Care, highlighted the need to exercise our duty of care in a precautionary way, to protect all staff and undertake proper risk assessments, including those from a BAME community, while the evidence base is explored. Health Boards and Trusts across NHS Wales have implemented current Public Health Wales guidance and high risk groups and staff who have different underlying health concerns are being advised to discuss concerns with line managers and look at appropriate duties taking a risk assessment approach.

Powys Teaching Health Board (PTHB) acknowledges its duty of care to protect the health and safety of all its employees; and support them during the pandemic, by understanding and responding to their needs and concerns. PTHB will undertake risk assessments to comply with the legal, moral and ethical duty, to provide a safe working environment for their employees based on relevant factors such as race, age, sex, known health risks, factors which are being identified as major determinants in respect of COVID-19 related deaths.

The Workforce and Organisational Development Team has agreed to complete COVID-19 risk assessments. This approach has been taken to assist with potential measures that could mitigate or reduce the possible risks of exposure to COVID-19. The risk assessment process was updated and formally launched by Vaughan Gething, the Minister for Health and Social Services, on 26th May 2020. The NHS have been advised that this risk assessment may now be used for all staff including BAME.

The new tool kit will be rolled out as risk assessments are reviewed by managers.

The risk assessments to date have been undertaken in order to ensure:

- Managers and employees are aware of the potential immediate and longer-term effects of COVID-19 on their employees / colleagues with protected equality characteristics and identified underlying health conditions;
- Managers and employees are able to identify the potential risk factors that may make employees more vulnerable to COVID-19;
- Managers and employees can access resources and support to understand and assess the risks:
- Managers and employees are familiar with the support available contained in the Health Board policies, such as Special Leave Policy, Flexible Working Policy, COVID-19 Extraordinary Home Working Policy and Guidance for Managers and Staff etc. and implement them fairly, equitably and with sensitivity and compassion;

- an employee's particular circumstances are taken into account and in doing so there is an acknowledgement that actions may need to be taken to protect their health and safety during the COVID-19 pandemic e.g. undertake alternative work / role, work from a different location, work from home, be medically excluded or shielded at home etc.;
- Managers and employees are aware of the services provided to support employees during the pandemic e.g. Silver Cloud; Counselling Services etc. Further health and wellbeing information and support is available via Occupational Health.

According to the Health Board's ESR data, out of a headcount of 2318 substantive staff, 49 staff have stated that they are from a BAME background. However, the Health Board has identified that a total of 342 staff have not disclosed their ethnic status on their ESR personal record. PTHB will therefore be required to offer and undertake a minimum of 49 risk assessments. However, this number could be higher, due to the non-disclosure of ethnic monitoring data by some staff on their ESR personal record. The Health Board has been proactive and encouraged staff to complete this information on ESR. COVID-19 daily bulletin issued on the 6th May 2020, encourages staff to update their ESR if they identify themselves as BAME.

As of 19th May 2020 the following assessments have been conducted:

- 34 completed risk assessments;
- 2 additional risk assessments have been completed as staff members identified themselves as BAME;
- 1 staff member on leave, risk assessment to be completed upon their return;
- 1 staff member on maternity leave, risk assessment to be completed upon her return;
- 13 requests for risk assessment have been submitted to line managers, awaiting outcomes.

PTHB may have to rely on risk assessment information in the future, should it have to evidence that it took all reasonable measures, to avoid serious illness or death of a BAME employee.

NEXT STEPS:

WOD Business Partners and Line Managers will ensure all BAME staff have risk assessments completed and appropriate measures will be in place to ensure their health and safety. This process is routinely used for all staff who are identified at risk. The outstanding risk assessments will be completed within the next two weeks, or upon the employee's return to work.

APPENDIX 1

All Wales COVID-19 Workforce Risk Assessment Tool

All Wales COVID-19 Workforce Risk Assessment Tool

Introduction

This Risk Assessment Tool has been developed to help people working in the NHS and Social Care in Wales to see if they are at higher risk of developing more serious symptoms if they come into contact with the Covid-19 virus.

We want to help you understand whether you may be at greater risk and to help you and your line manager to choose the right actions for you based on your level of risk.

Your employer has a duty of care to protect your health and safety at work and this includes understanding if you are at extra risk from COVID-19. This duty of care includes ensuring an equitable approach for all staff regardless of ethnicity or any other protected characteristics.

The next page sets out an overview of the risk assessment process. It has links to the latest guidance and information on the basic things that everyone can do to reduce their risk of COVID-19 infection, as well as the things that employers must do to support people who work for them.

Please use the resources as well as the Risk Assessment Tool to get the best results.

COVID-19 Understand your risk: Act to stay safe

What you need to do

Step 1 Check your risk – complete the Risk Assessment

Step 2 Understand your risk

A score of 0-3	Low risk
A score of 4-6	High risk
A score of 7 or more	Very High-Risk

Step 3 Identify the right actions for you

Your employer has a responsibility to put the actions in place with you

Step 4 Act now – Take the right actions

Observe Social distance

Practice Good Hand Hygiene

Rigorous Infection prevention and control

Deployment to a different area

Setting and PPE review

Workplace adaptation or Role redesign

Focus on your health and wellbeing

- Control existing health conditions
- Take Vitamin D supplement
- Manage your weight
- Boost your wellbeing

All Wales COVID-19 Workforce Risk Assessment Tool

Who needs to use this tool?

There are already well established arrangements and guidance for people who are in a 'Shielding Group' who should be staying at home or who are considered 'Vulnerable' according to Public Health guidance and so should already be maintaining strict social distancing.

This tool does not apply to these individuals as following existing guidance already mitigates the risk they face.

Shielding groups (Very High Risk) and Vulnerable Groups (High risk)

Everyone who is considered to be extremely vulnerable to Covid-19 infection will have received a 'shielding ' letter from the Chief Medical Officer for Wales Dr Frank Atherton, setting out the steps you should take to protect your health. These are known as "shielding" measures and advise staying at home until a further announcement is made, so this risk assessment is not necessary.

Vulnerable groups (adults who would normally be offered a flu jab for health reasons) are at higher risk and are advised to maintain strict social distancing. Appropriate adjustments to their role, redeployment or medical suspension should already be in place for these individuals.

Important note – if you are of a Black, Asian, Minority or Ethnic (BAME) background and under 28 weeks pregnant

Pregnant women may be particularly vulnerable and new information about pregnant BAME women indicates that they are at considerably increased risk throughout their pregnancy and so should avoid face-to-face contact with COVID-19 cases. This means no front line work where there is sustained community transmission.

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

How to use this Tool

The Tool asks a number of questions about you that are designed to identify whether you are at a higher risk from Covid-19. It asks some questions about your health, weight and ethnicity which may increase your risk of serious illness following an infection with Covid-19.

You may know the answers to the questions yourself, but if not you can discuss this with your line manager, workforce team, union representative, Occupational Health or advocate.

You may also want to consult your GP about the health conditions that are listed.

Please complete the questions and add up your score.

COVID-19 Understand your risk: Act to stay safe

We will continue to develop and improve the All Wales COVID-19 Workforce Risk Assessment Tool. If you have any comments or queries on the use or to improve the tool please email HSS.Covid19.WorkplaceAssessmentSubGroup@gov.wales

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

Step 1

Check your risk

Consider each risk factor that applies to you and total your score

Risk factor	Score
Age – Covid-19 seems to have a bigger impact on people who are older.	
• If you are aged between 50-59	1
• If you are aged between 60-69	2
Sex at birth – Covid-19 seems to have a bigger impact on males than females	
• Male	1
Ethnicity – Covid-19 seems to have a bigger impact on people from some ethnicities	
• Do you identify as one of the BAME or Mixed race groups as set out in this link	1
Existing Health conditions (Comorbidity) – Covid-19 seems to have a bigger impact if you already have other pre-existing health conditions. You may want to speak to your GP if you are not sure about these questions.	
• Cardiovascular disease Are you on any treatment for Hypertension (high blood pressure), Atrial Fibrillation (Irregular heart rate), Heart Failure, Previous MI (had a heart attack), had a stroke, or Transient Ischemic Attack (mini stroke)	1
• Diabetes Mellitus Type 1 or 2	1
• Chronic lung disease (including asthma, COPD, interstitial lung disease)	1
• Chronic kidney disease (any stage 1-5)	1
• Sickle cell trait, Thalassaemia trait or other haemoglobinopathy	1
Obesity – Covid-19 seems to have a bigger impact if you are overweight	
This link will help you work out your BMI – if your BMI is more than 30 OR If your waist circumference is: • South Asian Female more than 33 inches (84cm); Other BAME or white Female more than 34.5 inches (88cm) • South Asian Male more than 35 inches (89cm); Other BAME or white Male more than 40 inches (102cm)	1
Family history – Covid-19 seems to have a family susceptibility for some people, especially twins	
• Has a member of your immediate family (parent under 70, sibling, child) been in ITU or died with Covid-19	1
Total score	

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

Step 2 Understand your risk – what your score means in your workplace setting

	Score		
Workplace setting	**Low Risk 0-3**	**High Risk 4-6**	**Very High Risk 7 or more**
Community care	Continue with caution	Consider modified duties and PPE Review*	Work from home or non patient facing
Primary care	Continue with caution	Consider modified duties and PPE Review*	Work from home or non patient facing
Secondary care Non AGP	Continue with caution	Consider modified duties and PPE Review*	Work from home or non patient facing
Secondary care with AGP	PPE Review*	Redeploy out of Aerosol Generating Procedure areas	Work from home or non patient facing

Now arrange a time to discuss with your line manager to agree a plan and ensure you are appropriately protected. This may include a discussion with Occupational Health.

***PPE Review** – This should consider the work setting, review all Transmission Based Precautions and ensure the selection and correct use of PPE including training and fit testing

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

Step 3 Identify the right actions for you

Now you have completed yourCOVID-19 Risk Assessment score please discuss with your line manager, occupational health, workforce team, union representative or advocate to ensure you are appropriately protected.

Things I can do myself

Do the important things to maintain your safety in the workplace

- Observe good hand hygiene, with frequent use of soap and water or alcohol-containing gel.
- Maintaining a distance of 2 metres is an important aspect of the measures we must all take to minimise the risks of the spread of COVID 19. It is something we should aim to do in all aspects of our daily lives and anywhere in work where this is possible.
- Use appropriate personal protective equipment identified for your role and know how to use it properly.
- Observe isolation requirements for known or suspected COVID-19 cases.
- Ensure your infection control training is up to date.

Things my employer can help with

- Your line manager or union rep will help you use the tools and identify the right actions for you.
- Making adjustments
  - ➢ Can some or all of your duties be undertaken or completed in a different way
  - ➢ Can adjustments be made to enable you to work safely,
  - ➢ Can face-to-face contact with the public and home visits be limited or avoided
  - ➢ Ensure appropriate physical distancing within the workplace
- Will adjustments allow you to work from home
- If no adjustments can be made to mitigate your risk then temporary Medical Suspension may be considered.

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

Step 4 Act now – take the right actions

Following your discussions with your line manager record the agreed plan and ensure you set a time for review.

What reasonable adjustments have been identified and taken to mitigate your identified risks?

.....

Date adjustments were introduced*

.....

Date for review

.....

This may be time based or instigated by an event that impacts on your circumstances

* This should be signed and dated by both employee and line manager

All Wales COVID-19 Workforce Risk Assessment Tool – confidential once completed

Welsh Government are committed to ensuring that we learn quickly so that we can best protect you from harm due to COVID-19.

Your help and support in consenting to us gathering the evidence from your risk assessment is vital to inform further analysis so that we can better understand the disproportionate impact that COVID-19 is having on some individuals. This information will be used for this sole purpose in relation to COVID-19 and to continue to improve our risk assessment. It will only ever be your anonymised information that will be shared.

Information provided in confidence will only be used for the purposes advised and consented to by yourself

COVID-19 Understand your risk: Act to stay safe

We will continue to develop and improve the All Wales COVID-19 Workforce Risk Assessment Tool. If you have any comments or queries on the use or to improve the tool please email HSS.Covid19.WorkplaceAssessmentSubGroup@gov.wales

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.9

EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 4 JUNE 2020**
Subject:	**Support to Care Homes during COVID-19**
Approved and prepared by:	Executive Director of Nursing and Midwifery
Other Committees and meetings considered at:	This paper is based on the agenda, discussion and decisions made in the care homes multi-disciplinary team meeting and the executive oversight group, Quality Governance Group

PURPOSE:

The purpose of this paper is to:

- Articulate the support to Care Homes during COVID-19

RECOMMENDATION:

The Experience Quality and Safety Committee are asked to:

- **Discuss and note the contents of this paper**

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The adverse effects of the coronavirus within the care home sector in Wales and the UK is well rehearsed in the national media, with significant concerns in relation to the high incidence, spread and number of people who die, with confirmed or suspected covid.

Care homes in Powys have experienced a number of challenges related to the pandemic. In terms the themes emerging from care homes that have been escalated to the executive oversight group for consideration, registered nurse staffing and financial sustainability have been the key areas of concern.

Working together, the health board and Powys County Council have a long-established relationship with some progress made pre-pandemic in line with section 33 arrangements, which were designed to support and enable integrated working. The current situation provides an opportunity to increase levels of support to care homes and expedite progress where this is required.

Building on pre-covid19 service provision, and reporting into Gold, a care home workstream has been established, as expressed via Integrated Monitoring, Assurance & Escalation of Nursing & Residential Care Homes During the COVID19 Pandemic policy and standard operation procedure. The establishment of the multi-disciplinary team and executive oversight group have been key enablers in increasing the level of oversight, support and

intervention in the care home sector, with the aim of maximising the health and wellbeing of residents and staff in care homes, along with preventing and controlling the spread of infection.

Whilst significant progress has been made in a relatively short space of time, focus will be maintained on optimising the way i which the health board fulfils its duty of care to the residents of care homes in Powys.

DETAILED BACKGROUND AND ASSESSMENT:

The adverse effects of the coronavirus within the care home sector in Wales and the UK is well rehearsed in the national media, with significant concerns in relation to the high incidence, spread and number of people who die, with confirmed or suspected covid19.

The covid19 pandemic has led to a significant amount of contingency planning across sectors, including within the care home sector. The policy and strategy context that directly applies to residents within are homes changed considerably since the beginning of the pandemic, most recently aimed at increasing testing for residents and staff, along with additional controls related to admission, transfer and discharge into care homes.

There is a complex legislative backdrop to this sector, with a range of key stakeholders, including the at least 2 Welsh Government Divisions, Public Health Wales, Chief Medical and Chief Nursing Officers, Care Inspectorate Wales, providers, who may be large national organisations or small independent businesses, Registered Managers and Registered Individuals, Local Authorities, County Councils, health boards and primary care providers. The Older People's Commissioner for Wales, Social Care Wales and the Nursing and Midwifery Council are the main professional regulators, with Care Forum Wales and other organisations active in this sector. Additionally, residents of Powys may be placed out of county in other parts of Wales an England.

The Chief Nursing Officer for Wales has articulated that Nurse Directors should consider how they intend to support the care home sector in their area; Welsh Government has identified £40 million pan Wales to support the care homes sector, although allocation excludes additional expenditure related to registered nursing. An all Wales piece of work is underway, commissioned specifically to develop an NHS Wales service response to care homes. Additionally, care home providers have developed their own business continuity plans to cope with COVID-19 pandemic, to include ensuring support workers have the ability and training to administer medication.

There are 13 care homes providing nursing care in Powys. As in the rest of Wales and the UK, care homes in Powys have experienced a number of changes related to the pandemic. The services care homes provide are described in their statements of purpose, including caring for people with mental health or

nursing needs. Emerging evidence seems to suggest that there are a number of population groups that are at greater risk of infection with covid19, including people living in closed settings and those where cognitive impairment presents challenges in self isolation.

Working together, the health board and Powys County Council have a long-established relationship in this challenging arena, recognised as such by both agencies, with some progress made pre-pandemic in line with section 33 arrangements, which were designed to support and enable integrated working.
The current situation provides an opportunity to increase levels of support to care homes and expedite progress where this is required, for example in relation to the recommendations made within the 2019 internal audit report on care home governance, which identified limited assurance during autumn 2019.

Building on pre-covid19 service provision, and reporting into Gold, a care home workstream has been established, as expressed via Integrated Monitoring, Assurance & Escalation of Nursing & Residential Care Homes During the COVID19 Pandemic policy and standard operation procedure. The workstream and policy has enabled the establishment of a daily multi-disciplinary team meeting reporting into a twice weekly executive led oversight group. Meetings are well attended by colleagues from primary care, environmental health, Public Health Wales, Powys County Council and the health board, with a shared intention to maximise the opportunity to effectively support the care home sector in Powys during the covid19 pandemic.

The emphasis is on:

- developing, interpreting and acting upon an integrated SITREP that includes qualitative and quantitative indicators, providing accurate data for every care home within Powys
- **developing a framework that captures data and intelligence related to quality and safety, resident experience, activity and performance, finance and sustainability**
- **Agreeing an escalation matrix that articulates clearly the actions required of each agency in the event of difficulties occurring within care homes**
- **Partaking in formal meetings where assessment is undertaken and assurance gained in relation to care homes of concern**
- **Sourcing and implementing new guidance in relation to care homes as it arises. This area is dynamic wit fast changing expectation and requirement, for example, in testing, discharge and transfer arrangements**
- **Receiving updates by exception from other closed settings, for example, children's homes and supported living**
- **Supported through a programme management response, supporting lines of reporting and accountability**

These arrangements were initiated 28 April 2020, and are becoming established. The functioning of both groups is maturing and becoming more effective in managing the agenda in as an integrated team. Early learning has identified the following:

- **The effects of recent policy changes on the way in which care homes are populated, in relation to newly revised testing, admissions, discharge and transfer arrangements, the number of residents that have become deceased along with staff testing, absence, return to work and the cost of agency use, all have an impact upon the care homes ability to function effectively and efficiently.**

- **Care homes expressing concern about the financial implications of covid19 and their short, medium, and longer-term sustainability, and therefore that of the sector in Powys and beyond. This is a complex area where it is important to be clear in relation to the role, responsibilities and requirements of the commissioners, providers and the regulator, making clarity and transposers in decision making essential.**

- **Care homes facing difficulties in maintaining the registered nursing workforce, adversely affected by sickness, lack of substantive staff, use of agency staff where costs seem to have increased significantly. The ability of a care home to continue to function and to provide quality of experience to its residents is intrinsically linked to their ability to safely staff their homes.**

These are themes recognised across Wales and most health boards and local authorities, as commissioners with accountability for the care and experience of the individuals who reside in care homes, are working to identify means by which to safely manage these significant issues at this time, with a variety of approaches being developed.

In response to emerging concerns about the sustainability of the registered nurse element of the workforce in care homes, the following as potential measures that could be taken to strengthen registered nursing support to the care home sector during the covid19 pandemic:

- Daily review and assessment between the care home manager and named nurse, identifying areas of concern and means by which to address it.
- Access to specialist nursing support, e.g. infection prevention and control, respiratory nursing, tissue viability.
- Increased support and advice from complex care coordinators and community nursing teams, particularly in residential settings
- Provision of contact details of health board staff who have expressed an interested in working in care homes, facilitating a direct arrangement

- Health board support in gaining registered nurses via on contract agencies
- Health board support in gaining registered nurses via off contract agencies
- in extermis, whereby care home failure was likely if no action were taken, the health board would assess whether it could provide short term registered nursing support to with the aim of securing a safe and stable environment for residents whilst a plan is developed, in partnership with the provider. This would require agreement from individual staff and written agreement from the provider to adhere to the requirements of induction to protect the health and safety of employees

NEXT STEPS:

The establishment of the multi-disciplinary team and executive oversight group have been key enablers in increasing the level of oversight, support and intervention in the care home sector, with the aim of maximising the health and wellbeing of residents and staff in care homes, along with preventing and controlling the spread of infection. Whilst significant progress has been made in a relatively short space of time, focus will be maintained on optimising the way in which the health board fulfils its duty of care to the residents of care homes in Powys.